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ABSTRACT

This survey reports on 13 free clinics in Ann Arbor, Minneapolis, Baltimore, Washington, D. C., Somerville (Mass.), New Orleans, and Metropolitan Los Angeles. It defines free clinics and notes various types, such as street clinics, neighborhood free clinics, women's free clinics, youth clinics and sponsored clinics. A short history and philosophy of free clinics is presented along with the functional aspects such as facilities, record systems, and types of services provided. The survey also discusses funding of free clinics and makes recommendations for action for free clinics in the future. Copies of several issues of a newsletter called People's Free Medical Clinic are included in this article but are available only in hard copy. (EK)

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A GENERAL SURVEY OF FREE CLINICS AS ALTERNATIVES TO EXISTING HEALTH CARE INSTITUTIONS

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A GENERAL SURVEY OF FREE CLINICS AS ALTERNATIVES TO EXISTING HEALTH CARE INSTITUTIONS

This report is the result of four weeks of on-site visits to 13 free clinics in Ann Arbor, Minneapolis, Baltimore, Washington, D. C., Somerville (Mass.), New Orleans, and metropolitan Los Angeles, and discussions with people associated with these and other free clinics in these cities. The report is not a comprehensive survey of all free clinics in the country.

PART I. Theory and Development of Free Clinics

SECTION A: Introduction, Definitions, and Types of Free Clinics

The mere existence of some 250 free clinics throughout the country treating well over a million people a year is in itself a critical indictment of the health care delivery system in this country, for if it had been doing all along what it was meant to do, there would be no need for free clinics! Although the original genesis of free clinics was the intense need of the youth counterculture (essentially white and middle-class) which exploded into being in the mid-1960's, free clinics today serve communities which cover the entire range of societal isolation in America - Chicanos, blacks, American Indians, Orientals, the poor, the near-poor, women, the elderly, street people, youth... Free clinics are vital and dynamic nuclei in a growing health movement which cries out "Health care is a right, not a privilege!"

Definition of Free Clinics

What makes "free clinics" today any different from the centuries-old charity clinic or the Chicago Board of Health Neighborhood Clinic? An often-quoted statement of David E. Smith, founder of the first free clinic (Haight-Ashbury Free Medical Clinic in June, 1967) says it succintly, "The 'free' in free clinic refers more to a state of mind than to the absence of a cashier. "Free" means an entire philosophy of service in which the PERSON is treated rather than his or her disease; it is an important distinction. In a free clinic the focus is on health CAREING for the whole person, on providing a service which is free of

red-tape, free of value judgments, free of eligibility requirements, free of emotional hassles, free of frozen medical protocol, free of moralizing, and last and least, free of charge.

For the purpose of defining free clinics, the Southern California Council of Free Clinics, for example, sets forth the following criteria:

A. A free clinic is a private non-profit community-based corporation offering a variety of direct health and social services, one of which must be either primary medical or dental, without direct monetary charge to the client.

B. The governing body of a member corporation shall be comprised of volunteer community professionals, non-professionals, and interested community individuals, who actively participate in furthering the operation and purposes of the organization.

C. If a free clinic provides medical services, it has obtained, or is in the process of obtaining, a State of California Health Department Charitable Clinic License.

The Council further stipulates the free clinics must be "...providing direct public health and related social services on a non-discriminatory basis, with an attitude and atmosphere acceptable to those individuals who cannot or will not go to traditional facilities."

In a study done about two years earlier, Jerome L. Schwartz defines a free clinic as a social agency which provides:

1. Direct delivery of either medical, dental or psychological and drug abuse care.

2. Presence of a professional relevant to the service provided.

3. Services available to everyone without red tape or eligibility test.

4. Free services (although small charges for specific services, e.g., 50 cents or $1, or donations may be requested).

5. At least some volunteer professionals on the staff.

6. Specified hours of services.

7. Care provided from a facility.

Although all those criteria hold true at present, I would modify #3 above to read, "Services available to everyone without red tape or eligibility test beyond area of residence; referrals made to adequate and sufficient resources for all others." Because of a super-abundance of patients, some free clinics have been forced to establish loose area boundaries in order to avoid becoming the same type of institutions they are criticizing: rushed, bureaucratic, impersonal. Nevertheless, they will always treat emergencies, and for less critical problems will do some sort of referral, depending on the resources available and the ability of the patient to cope with various alternatives.

History of Free Clinics

As youthful alienation in the mid-60's began to express itself in experimentation with drugs and sex, personal relationships, clothing and hair, Eastern religions and electronic music, it generated radically different lifestyles which in turn incurred the moral outrage and practical rejection of conventional society. Young hippies not only found themselves ostracized for their flamboyant appearance, but far worse, discovered that it was virtually impossible to obtain adequate social services. In particular, the medical establishment was not only unable to deal with the problems of unorthodox youth, but unwilling even to try. Large numbers of young people found out what minority people had known for years; that just as with many other institutions, there is a dual system of health care - one for the rich and middle-class (overwhelmingly white), and one for everybody else! It was out of this experience plus acute need and desperation that free clinics were born.

Historically the first free clinics were opened by concerned professionals who sought to provide emergency acute care for drug problems to young street people who could not get this help anywhere else, but these clinics quickly found themselves providing regular medical care as well; usually for drug and lifestyle-related disorders (hepatitis, VD, gynecological infections, birth control information and devices, problem pregnancies), but sometimes also for maladies which had gone unattended for a time and worsened, due to the patient's fear of established medical facilities

(upper respiratory infections, urinary infections, strep throat).

The Haight-Ashbury section of San Francisco was rapidly becoming a national youth mecca; Los Angeles was the ascendant rock music capital of the country; and the entire psychedelic youth sub-culture gravitated irresistably toward the West Coast. As necessity is the mother of invention, so California was the mother of free clinics. Even today the heaviest concentration of free clinics can be found in California, with the rest of the West Coast not far behind.

In June of 1967, the Haight-Ashbury Free Medical Clinic opened its doors; throughout that year "the Free Clinic" of Los Angeles was in various stages of organization and service; in October the Open Door Clinic in Seattle began. By the end of 1969 there were upwards of 70 free clinics throughout the country.

But not all of these clinics were established to meet the needs of young drug-oriented hippies. Because the mass media revelled in providing national exposure to this diverse, intriguing, sometimes bizarre and easily sensationalized youth sub-culture - in all its possible aspects--even today the activities of free clinics have retained an image among the uninformed of stoned-out freaks receiving free - and therefore, somehow inferior - medical treatment in second-rate facilities from do-gooder doctors who are slightly weird themselves. This image is not only grossly unjust to those clinics which serve transient street people, but it totally fails to comprehend the diversity of free clinics and the gigantic proportions of unmet health needs in this country.

Types of Free Clinics

Street Clinics

The early and most visible free clinics were primarily street clinics and they are still a large proportion today. Street clinics work primarily with transient youths from middle teens to late twenties, almost always provide drug abuse care and counselling, and frequently run a 24-hour hotline for emergency aid. Most medical care is for drug-related illnesses or sex-related problems. Street clinics are usually located in the "hip" part of town - the French Quarter of New Orleans, the Georgetown section of Washington, D. C., Haight-Ashbury in San Francisco.

Neighborhood Free Clinics

The other major type of free clinic is the neighborhood clinic. Whether its founders simply borrowed the street clinic concept and adapted it to neighborhood needs, or took the OEO Neighborhood Health Center model and broke down its rigidity and bureaucracy, is impossible to say. In any case, neighborhood free clinics have generally been started by community residents, inhabitants of a particular housing project, or political organizations (e.g. -- the Black Panthers, the Young Lords, the Brown Berets, the Young Patriots) in poverty (usually minority) neighborhoods where there is little if any emphasis on drug problems; neighborhood free clinics provide general medical and sometimes dental care for familites, pregnant women and elderly citizens in the community. And many of the street clinics are beginning to see an increasing number of area residents of all kinds come into the clinic for care. Some examples of neighborhood free clinics are El Barrio in Los Angeles, which serves Chicanos - a good 75-80% of whom do not speak English; the Young Patriots Community Health Center in the Uptown section of Chicago, which serves poor whites of primarily Appalachian origin; the Baltimore People's Free Medical Clinic in the Waverly area, which serves a diverse community of welfare and working-poor, both black and white.

Women's Free Clinics

A newly emerging type of clinic is the women's clinic; whether as an autonomous facility or as a special night set aside strictly for women's health needs (males receive only emergency treatment, otherwise are asked to return another night), control of the program rests totally in the hands of women volunteers and patients. All staff are women except for some doctors (and that only out of sheer necessity in most cases); while these clinics provide general medical care for women, the major diagnoses are gynecological - ranging from simple vaginal infections to some hysterectomies, and including birth control information and devices, proglem pregnancies and abortion referrals, VD, breast checks and pap smears. Women's clinics also have rap groups in such areas as female anatomy, natural childbirth, concepts of the family, problems of young mothers, nutrition, social and political problems of reproduction, self image. While at present there are not a great many autonomous women's clinics - there is the Somerville Women's Health Project in Massachusetts, two women's clinics in Los Angeles, one in Portland, Oregon - there is an increasing trend towards at least establishing a women's night in most free clinics, and many women's groups are organizing clinics in various parts of the country.

Youth Clinics

There are two further types of free clinics identified by Jerome L. Schwartz in his survey of free clinics done in 1970: youth-type clinics and sponsored clinics. According to Schwartz, youth-type clinics were generally organized by adults, service clubs or official commissions and boards, sometimes after a teenage death from drug overdose has shocked the community into action. These clinics are organized to serve mainly high-school kids, and usually provide drug programs limited to education and counselling (do not deal with drug emergencies such as over-dose or bad trips), birth control information, pregnancy testing and counselling, and some medical care. The largest patient group is 16-18, but may range from 10-24. Youth clinics such as Teenage Medical Service in Minneapolis, the Open Door Center in Alhambra, and the Foothill Free Clinic in Pasadena usually see teenagers from all over the city, but rarely see transients.

Sponsored Clinics

The other type identified by Schwartz is the sponsored clinic; the only apparent examples of this type are the six free clinics run by the Los Angeles Country Health Department, which are modeled after the street clinics and serve roughly the same type of patient. However, Schwartz notes, the average age at these clinics is lower than that at the street clinics; further, although every other type of free clinic is supported almost entirely by volunteer labor (both professional and non-professional) almost all professionals at the sponsored clinics in Los Angeles are paid on an hourly basis.

By far the vast majority of free clinics are either street clinics or neighborhood clinics, with women's clinics emerging as a trend of the future (this is also partially predictable based on the dramatic increase in the area of women's rights in the last several years); it is impossible for me to even estimate the relative proportions of the different types, and no current research has been published on a national basis.

PART I. Theory and Development of Free Clinics

SECTION B: Philosophy of Free Clinics

Although most free clinics were born out of acute need and intense desperation, rather than a strong vision of social change, from that very experience has come a fairly universal and consistent analysis of why free clinics have had to exist, what they are and where they are going, and what the effects of their existence should be. Much of this has been crystalized only recently after the debacle of the Second Annual National Free Clinic Council Symposium in January of this year (see Health-PAC BULLETIN No. 38 - The Selling of the Free Clinics, February 1972).

"Health care is a right, not a privilege!" can be found on the walls of almost any free clinic in the country. Health is seen in the larger context of caring about people, not just their diseases, of providing a healthy societal environment, not just treating the many symptoms of an unhealthy one. Free clinic people feel that major institutions, especially the medical establishment, have failed to do this because their focus is on money-making rather than on fulfilling human needs, or providing the CARE in health care. Recognizing that the personnel, equipment, and facilities necessary to do this are already overwhelmingly owned by existing institutions, free clinics see as their ultimate goal the change of existing institutions to provide basic health care for everyone, in a manner acceptable to all. While all clinics agree on this goal, they do not all agree on how to accomplish it, and there is frequently a great deal of disagreement even within a clinic.

All free clinics perceive themselves as models of how health care ought to be delivered, though of course in a good many ways they are not, and would be the first to admit that practice has not always measured up to theory.

De-mystification of Medicine

Two major goals in changing the way health care is delivered are the demystification and deprofessionalization of medicine. Demystification involves teaching the patient that he/she is capable of understanding the processes of treating disease, though perhaps not on as sophisticated a level as trained medical personnel; still the patient has the right to know what the nature of his/her problem is, what caused it, and if there are options in its treatment, to make an educated choice. The doctor is not God.

Patient Advocacy

Although frequently the responsibility for ensuring that this happens falls upon the professional staff, some clinics have or are developing a "patient advocacy" program. A patient advocate is usually a non-credentialed health worker, sometimes a student in the health professions, but just as frequently a trained volunteer who has enough informal knowledge to ask the right questions. His or her role is to facilitate communication between doctor and patient, to ensure respect for the patient's rights, and if necessary, to protect the patient from physical or emotional abuse.

At the Baltimore clinic, a patient advocate meets the patient when he/she arrives, takes the patient's history and vital signs, discusses the nature of the patient's complaint. If it turns out to be rather specific, as in the case of, say, suspected VD or suspected pregnancy, the advocate will explain the symptoms, the lab tests, and possible treatments. After the patient has seen the doctor, the advocate will again sit down with the patient and discuss what happened, whether or not the patient was satisfied with his/her treatment, and understood what was going on. The advocate will schedule an appointment, arrange for follow-up of lab tests and take care of any referral which may be necessary.

The Ann Arbor clinic is designing a program of referral patient advocacy, where an advocate will accompany the patient to the out-patient department of one of the local hospitals and facilitate the same process there between doctor and patient. In some clinics, the advocate accompanies the patient into the examining room (with the patient's permission); the Ann Arbor clinic will be doing this at the hospital. This is to protect the patient from possible emotional abuse by the doctor, especially when the patient has a socially stigmatized complaint such as VD or unmarried pregnancy, and to ensure that the patient makes a choice of treatments, if there is a choice to be made.

Preventative Care

Free clinics also emphasize the need for preventive care, but few have had sufficient energy above and beyond keeping the clinic operating to translate this concept into action. For this reason, they advocate the establishment of a

series of neighborhood health centers providing free high-quality care to the community; hospitals should close their out-patient care, while community centers which are not extensions of the hospital, but community-cortrolled, provide primary acute and preventive care. Most clinics see themselves as doing this now - albeit sporadically - and many wish to exist in perpetuity, while others feel that the goal of their existence is not to exist - because the medical system has changed to the point that there is no longer any need for their existence.

Some clinics have gone so far as to announce an intended closing date, usually one or two years in the future. They feel that by continuing to exist they protect the medical establishment from challenge by "taking the heat off" - if they provide the service to a medically indigent community, then there is no reason for the established institutions to do so. This may very well be the case - in New Orleans, the state welfare department is now referring patients to the H.E.A.D. clinic! Some free clinic people have suggested that this also may explain why a few hospitals have become more willing to assist free clinics.

Deprofessionalization

Deprofessionalization involves breaking down the monopoly on health skills which the doctor has had for so long. This is not only theoretically desirable but emminently practical because of the shortage of doctors, particularly in the communities which free clinics serve. It is not a new concept; what is new is the attempt, coupled with demystification, to destroy what free clinics feel is the professional elitism which has characterized the medical profession for so long. Free clinics are attempting to demonstrate that not only can a person understand what is going on in his/her body, but also that he/she can learn to do some of the things necessary to find out, and all of the things necessary to keep the body in good health, from simple immunizations to basic nutrition. The doctor's greater skills are necessary for acute care, but not for preventive care.

Experience in free clinics has given rise to several issues. Where does health care stop? If a clinic is treating a large number of cases of lead poisoning, doesn't it make more sense to attack the causes of lead poisoning? Or does responsibility stop at the door? Free clinics are constantly experiencing a tension between treating symptoms and dealing with their causes.

And as clinics are increasingly overburdened with patients (Long Beach Free Clinic in California turns away as many patients as it sees, and it sees 40 to 50 people a night!), they experience a growing realization that they can't possibly treat everyone who needs their help. Nancy Lessin of the Ann Arbor clinic makes the following analogy:

> A group of people are having a picnic by the river. All of a sudden they hear someone screaming and see a person being swept down the river. One of the picnicers jumps in and saves him. Several minutes later the same thing occurs - someone comes floating down the river kicking and screaming, and another picnicer jumps in the river and pulls the person out. Soon several more people come barreling down the river... more and more picnicers are having to jump into the river to pull them out...Pretty soon the river is full of kicking, screaming, drowning people and picnicers pulling them out, and FINALLY a person get up and announces, "I'm going up to the head of this river and find out who the Hell is kicking those people in!"

Free clinics find themselves increasingly aware of their dilemma: responsibility for providing care for people who cannot get it elsewhere, responsibility for changing the system so they can get it elsewhere, responsibility for changing the system so they won't have to get so much of it anywhere.

Few clinics have been able to resolve the dilemma by making a conscious decision to concentrate on any one of the three areas. See Attachment A for a statement of the Ann Arbor clinic which has decided to concentrate on changing the health delivery system at the local level.

PART II. How Things Work Out in Practice

SECTION A: Facilities

Free clinics are usually located along the main drag of whatever community it is that they are serving; they are not only accessible but a feature of the landscape. Housed for the most part in old buildings which were never intended for such use, they have awkward layouts and unconventional decor. There is an always-overcrowded waiting room filled with used furniture, posters on the walls painted by a grateful patient or just someone filled with the urge to rise above grafitti, a sign urging donations and a prominent donation can, a bulletin board or section of bare wall used for notices of rides and apartments wanted, lost animals, community events....on clinic nights the waiting room is noisy, friendly and chaotic, in stark contrast to the usual medical waiting room.

Free clinics have two or three small examining rooms; a dispensary and one or two labs tucked into corners or a closet; an administrative office of some sort, and one or two counselling rooms. Additional facilities depend on the additional services offered. There may be a dental room, an x-ray lab, a playroom.

All equipment is donated, from examining tables to instrument trays to the second-hand furniture. Frequently, a doctor or hospital donates old equipment when purchasing new, sometimes a doctor's widow is breaking up his office and donates the contents. The American Dental Association gave the Baltimore Clinic two dental chairs and a dental x-ray unit, saying they had never heard of a free dental clinic; obviously, they weren't listening, since many California clinics have dental clinics. It isn't the equipment that's hard to come by so much as the dentists. El Barrio clinic in Los Angeles can't even find a dental student willing to help set up the dental equipment properly.

Record Systems

Records are kept to a minimum in order to avoid both red tape and legal hassles. Free clinics are always concerned about confidentiality of patient records, particularly in case of police harrassment. H.E.A.D. Clinic in New Orleans keeps records by assigning numbers, which only the patient knows. If he/she loses or forgets the number, new records are started. Also, all patients sign consent forms that they are eighteen, and the clinic treats them in good

faith; this prevents the clinic from being sued for treating a minor without parental consent. All this may seem paranoid, but two years ago the H.E.A.D. clinic was "raided" by police and only the consent forms (which were tested in court) saved clinic staff from imprisonment; only the number system made the records anonymous (some were scattered about, others confiscated by the police).

Treatment of minors is an area where all clinic people agree - the law requiring parental consent only forces a minor to lie or to remain unhealthy and unhelped. Few clinics have been active in attempting to change the law across the board, though some have helped to get new laws which free minors for VD treatment and/or birth control information.

While their laboratories are small free clinics do provide a large number of tests. They do VD and pregnancy testing, urinalysis, pap smears, throat cultures, and a whole range of blood tests. What they can't do in their labs, they send out to a commercial or hospital laboratory which does them either for free or for minimum costs. It would take someone with a good background in this area (which I do not have) to evaluate the adequacy of this service

Almost all clinics have a dispensary, though it is called a pharmacy for familiarity's sake (a dispensary does not contain narcotics), which is operated by a pharmacist. Clinics are well aware that health is restored **not** after the diagnosis, but after the treatment. It makes little sense to tell a patient what is wrong and then not help him or her to correct it; the dispensary gives free drugs to ensure treatment.

Clinics have a difficult time obtaining sufficient drugs; what they do have is charmed from a drug salesman or sometimes "liberated" from hospital supplies by some freindly staff member. Drug salesmen in some places have started giving the doctor only one of a box of physician's samples and the rest to a free clinic. Sometimes a doctor will order drug supplies for the clinic. People who've stopped taking birth control pills frequently give the rest of their supply to a clinic. Some clinics receive supplies of penicillin or tetracycline from the Public Health Service on the basis of the number of VD patients they treat, but the amount rarely is sufficient. Free clinics must hustle for drug supplies just as they hustle almost everything else.

PART II. How Things Work Out in Practice

SECTION B: Services

Medical

Although almost all clinics see the whole range of medical problems, certain problems are more common in some than in others. Free clinics treat a major portion of VD because people know that they can get good, compassionate treatment there and don't have to pay the price of a moral lecture. Los Angeles free clinics together see 40% of the VD treated in the metropolitan area. The Washington Free Clinic alone sees 16% of the District's VD cases. And people know that they can get treatment. One evening a man came into H.E.A.D. Clinic in New Orleans for VD treatment; he had just been refused treatment at the public health clinic because he was unable to give the name of his sexual contact. With a VD epidemic running rampant, that a public health clinic should refuse treatment to anyone for any reason is disturbing. The incident illustrates why free clinics had to come into existence.

Street clinics are more crisis-oriented than other types of free clinics. Although the number of bad trips is decreasing, they still handle overdoses. Street clinics see a far greater number of drug-related illnesses also, such as hepatitis and upper respiratory infections resulting from a generally run-down condition. Street clinics are usually open only at night, though many of them also operate a 24-hour switchboard for crisis referrals. Consistent with the needs of their clientele, they generally provide first-aid, general medical care, VD and pregnancy testing, VD treatment and problem pregnancy counseling with abortion referral if desired, and drug help, every clinic night.

Neighborhood clinics, on the other hand, do a wider variety of care because they serve a wider range of people; neighborhood clinics do less crisis care and more well care. They frequently have regularly scheduled pediatricians and nutritionists, do employment and school physicals, prenatal and infant care, immunizations; they have also done outreach programs as well, such as the Young Patriots Clinc in Chicago which did door-to-door kidney screening, explaining why this was important to people and encouraging them to come to the clinic if treatment was necessary. It's been my understanding that a significant number of people whose test results indicated a need for treatment did go

to the clinic and seek it. The Black Panthers in Chicago have screened sickle cell anemia outside supermarkets on Saturday mornings. And at the least, many clinics have sent volunteers door-to-door in their area talking about the clinic and inviting residents to visit the clinic. This approach has met with a great deal of success, but requires great time and energy. Most clinics would like to do more outreach than they presently do, and some have definite plans to do so.

The Baltimore clinic in the Waverly area has been regularly screening its patients for TB, since Baltimore has the highest rate of TB in the country, and Waverly the second highest in Baltimore. Just as the Public Health Service was making significant progress on controlling TB, large chunks of money were switched to VD, and now the Baltimore clinic notes again a steady rise in the incidence of TB, for which they are continuing to test.

Sex-Related Health Care

A large proportion of the problems which people bring into free clinics are sex-related--VD, problem pregnancies, birth control and abortion. There is a free clinic starting in Minneapolis, the Family Tree, which will work only with sex-related problems, and there will probably be others before long. The majority of the work that Teenage Medical Service in Minneapolic does with young people aged 10 through 19 deals with sex-related problems, although the clinic was opened to provide general medical care.

Free clinics have by and large been the only places where young people could go for sex-related health care and receive compassionate treatment without being lectured to or moralized at. This has been a major failing of the established health care system--the unwillingness to treat these problems seriously, honestly, and compassionately. Although some medical schools are finally beginning to recognize in their curricula that doctors need more training and exposure in human relations, it will take years before any real impact is felt by the society as a whole. In the meantime, young people will continue to take these problems to free clinics.

Dental Care

Although all clinics would like to be able to provide dental care, and some clinics have the equipment, few clinics have been able to find dentists. Those who have are deluged with patients. The American Indian Clinic in Compton, California finds that 50% of its patients

seek dental treatment. Of the 40 odd clinics in Southern California only 3 other clinics have dental services. As mentioned previously, the Baltimore clinic provides dental care, but none of the other clinics encountered did. Dental care is an especially acute problem in neighborhood clinics because the community they serve is usually people who have been deprived of care for years.

Counseling

Two types of counseling are provided in free clinics--rap groups and one-to-one sessions. The former are usually run by nonprofessional volunteers with a special ability in working with groups; they may have had some informal training by professionals, or may simply show a knack. Rap groups sometimes are started in the corner of a waiting room by one of the nonprofessional volunteers who discover that there are several people with the same specific complaint of some sort; these spontaneous sessions are group education and counseling at the same time. Or there may be a regular pattern of rap groups with several particular volunteers who perceive this as their job; there may be a VD rap group on one night and a birth control rap group another, a nutrition session on a third--and these times are usually posted on the clinic walls somewhere. Rap groups on birth control, pregnancy and abortions, as well as one-to-one counseling on the same subjects are usually handled by women. I did not examine the individual counseling programs except to note that most of it is done by trained professionals; individual counseling on problem pregnancies, however, is done primarily by women, most of whom are nonprofessional.

Related Services

Related services arise as the needs of the community express themselves. L.A. Free Clinic which serves large numbers of young runaways and transients when they first get to California has a wide variety of related services: a job co-op, legal and draft counseling, a free university, and at one time a free food program. Many street clinics provide similar services. H.E.A.D. Clinic in New Orleans also has a "ride-board" on which people post rides-and riders-wanted notices. The Baltimore clinic has the only men's counseling group I encountered, although I imagine it is not unique. El Barrio in L.A. does some counseling of immigrants.

Referrals

A major service, though it is certainly not regarded as such, is referrals. That, in fact, is how the Ann Arbor clinic got started. Drug Help, Inc. had located a physician who accepted referrals for medical care and had set a sliding scale of fees based on ability to pay. One day in August of 1970 he encountered Nancy Lessin, who was working at Drug Help, on the street and said, "Please don't refer any more patients to me...I'm getting too crowded...I can't handle it!" And she said, "We'll have to start a free clinic!" Six months later, in January 1971, the Ann Arbor Free People's Clinic opened its doors. Now the clinic has evolved full circle, and recognizing that a free clinic isn't the answer either, has begun a new approach (see Attachment A).

Referrals are handled in all sorts of ways, depending on the problem and the patient's ability to pay. Referrals to hospitals for both out-patient and in-patient care are usually "back-door," through one of the volunteer professionals who may practice in a hospital or who has good "connections." Some clinics have a major portion of their professional staff working in a particular hospital (e.g., most of the professional staff at Southside Medical Clinic in Minneapolis come from Northwestern Hospital) and referrals can be handled informally through that hospital; if the patient is really poor, usually something can be worked out with the hospital. Adverse publicity is sometimes an effective threat hovering in the background.

Clinic staff develop informal channels for referral, normally based on good personal relationships. They have usually developed an excellent working knowledge of what is (and isn't) available in medical facilities in the area, and community knowledge of other kinds of services is circulated into, through and out of free clinics.

By and large, their services provided in free clinics are consistent with both their clientele and their resources. Free clinics are not so unique in what they do as in how they do it.

PART II. How Things Work Out in Practice

SECTION C: Staff

People cannot possibly be into providing free clinic health care for money; the very few who are paid receive bare subsistence level salaries which seem to average around $50-$60 a week, often less. Usually these people are young, single and independent, used to living off the streets. It would appear that most clinic coordinators average around the ages of 25 to 26 and many have been involved with the free clinic movement for several years.

Almost all staff other than clinic coordinators are volunteers. Clinics acquire them in a number of ways and for a variety of reasons. Each clinic usually has a pool of professional staff who are scheduled to serve in the clinic once a week, once every two weeks, once a month--depending on the size of the pool. Clinics try to screen their volunteers, but because of the shortage of volunteering professionals rarely "fire" any. This is an issue within free clinics--the tension between "hassle-free" care and no care--and is another experience which has led some of them, particularly free clinics in Chicago, to begin pressuring medical schools for changes--more minority admissions in particular--so that physicians in the future will be more responsive to the unmet health needs of the culturally isolated.

On a typical clinic night, the staff may consist of 6 to 12 professionals and 9 to 18 noncredentialled health workers (both health professions students and volunteers from the community who may or may not have had some training). There are usually 1 to 3 doctors, 1 to 3 medical students, a pharmacist, 2 to 5 nurses (about half LPN's and half RN's), a lab technician (licensed) and 1 or 2 lab assistants (non-licensed "trainees"), 2 to 3 professional counselors, 2 to 3 women's counselors (nonprofessional with informal training to deal with birth control, problem pregnancy, and abortion), 1 or 2 receptionists, 1 or 2 clinic coordinators, and 3 to 6 volunteers who fill a variety of roles and needs--they may act as patient advocates, keep the children happy, drive people to a hospital, start rap groups, restock the examining rooms.

Outside of the doctors, everyone else's roles are fairly fluid and difficult to define. Everyone does a little of

everything. In some clinics everyone can take vital signs, do lab tests, explain most medical treatment, and generally fill in for one another. Most clinics seem to have to hustle professional staff only when they are first setting up--and then, usually through informal, personal contacts. Almost all clinics have doctors volunteering after the first few months they are open, and for a variety of reasons. Those doctors who think they are "helping those poor people" with somewhat of a condescending attitude don't last long. Either they drop out quickly themselves or the clinic coordinator "forgets" to schedule them. These doctors as well as any staff with this attitude are least acceptable to free clinics. Some professionals think it's going to be "a groovy trip" to do "freak-medicine" and they don't last very long either. Needless to say, street clinics have more problems with that attitude, while both street and neighborhood clinics have trouble with the patronizing "I'm so noble" attitude. Many doctors feel slightly guilty about their privileged position in society, the money they are making, and medicine's failure to meet the health needs of whole groups and classes of people; this feeling is true of other professionals as well. While exceedingly few have given up their lucrative professional positions, most feel that working in a free clinic is "doing something concrete about the problem."

But more often the free clinic provides an alternative for young radical health professionals and health students who see it as a way to translate rhetoric about changing the system, into action. It is a way to demonstrate that medicine can be practiced differently, can be personal and flexible, can respond to varied communities, and doesn't have to be elitist. Some free clinics have been started by medical and health students for this very reason.

Untrained volunteers work at the free clinic for a variety of reasons. Many want to become involved in something "relevant," many want to meet new people and are looking for a sense of community, many wish to learn more about medicine and health. Some people, after working in a free clinic for awhile, have been highly motivated to go back to school for professional training. Some have taken professional training while continuing to work in the clinic solely for the purpose of providing a skill which the clinic needs (e.g., two people at the Baltimore clinic studied for and received licenses to do a special TB test).

Training

While a few free clinics have minimal formal training for their para-professionals set up in conjunction with a hospital, medical school or public health clinic, most have a sort of over-the-shoulder apprentice system. Some of the women at the Baltimore clinic are learning to do pelvic examinations (the exact situation is always explained to the patient, and her permission obtained first. There have been suprisingly few refusals.), but that is the most sophisticated level which any of the informal training has yet reached. While this may raise the objection that free clinics are doing exactly what they have criticized hospitals for--using their patients as teaching tools--in a free clinic, the patient is always free to refuse and training is never a condition of treatment.

Because of this informal approach, and the lack of even minimal research going on in most clinics, it is difficult to describe or categorize training, or even to know exactly how much of it is done, how many people have been trained, and how good it is.

For many student professionals, simply working in a free clinic is training. They obtain practical experience, and studies take on a new human dimension. Additionally, free clinics provide a counter-balancing experience against the professional elitism and emphasis on specialization which is endemic to medical schools. Many free clinics have been organized by professional health students (e.g., Edgemont Community Clinic in Durham, North Carolina; Cotton Free Clinic, Cotton, California), who have learned valuable lessons in consumer participation in the process.

Some medical schools in the South and Southwest have formal arrangements to rotate students through free clinics, usually neighborhood clinics started by medical students themselves, and this sort of a program once again raises the question about using medically indigent people as teaching tools. At the University of Minnesota medical school, students in the community health program may work in any free clinic to fulfill their field-work requirement, which alleviates some of the difficulties by dispersing health students throughout the area. Many health students

are used as patient advocates because they have enough knowledge without further training to comprehend the treatment process. In some clinics, 3rd and 4th year medical students diagnose under the supervision of a licensed M.D., who may not even be in the examining room. There is a wealth of information and a variety of relationships between health students and free clinics that certainly bears investigating.

The free clinic's dependence on volunteer labor causes some serious problems. Although professional and patient may relate to one another on a human basis in each encounter, obviously, if the patient sees a different doctor/nurse/psychologist every time he or she goes to the clinic, no real relationship can develop. Volunteer professional labor makes it difficult to <u>really</u> fulfill the intent to treat the whole person; the fullness of a human being is only revealed in a relationship rather than an encounter. The larger the clinic, the worse this problem is; in smaller clinics, patients make an effort to come in on the nights when "their" doctor is scheduled, and wholeness of care is not so impossible. Baltimore People's Free Medical Clinic seems to have done a remarkable good job in providing continuity of care; many patients regard the clinic as their primary health care unit, and the clinic makes an effort to schedule patients to see the same doctor.

This problem has been alleviated somewhat where non-professional staff are regularly scheduled on a weekly basis, and the patient can develop a continuous trust relationship with a particular patient advocate, for example, or a counselor, perhaps.

Further, every clinic has gone through nights when no doctors showed up and there was a frenetic scramble to "coerce" someone into coming in; meanwhile the waiting room was filling up rapidly. Some nights clinics have not been able to find anyone and have had to refer-out emergencies and ask everyone else to return the next night.

The cost to professionals in emotional terms is very high; they are essentially volunteering what little leisure time they may have; health is a demanding field anyway,

and in a free clinic professionals find themselves being expected to cope with all sorts of things. In one clinic, after the doctor had prescribed an expensive battery of tests, the patient advocate challenged him to figure out a way to get them done free since the patient had no money;[2] Professionals are expected to step outside the conventional medical protocol which has been ingrained into them throughout their professional training. Nurses are expected to express it if they disagree with the doctor, doctors are expected to behave as part of the team rather than the head of it. If doctors are specialists they find themselves practicing general medicine as well; and their "bedside manner" is always vunerable to open criticism. They must take the time to reduce diagnoses to plain English, something many doctors rarely do. Nurses play receptionist/counselor/therapist/patient advocate roles. Pharmacists may have to advise a patient, on-the-spot, of drug action and possible drug side-effects. Lab technicians as well as almost all other professionals also become informal teachers.

This loosening up of roles is exciting and challenging, but it is also exhausting, and is responsible for the syndrome known as "burn-out." The speed of "burn-out" occurs in direct proportion to involvement in any alternative institution, not just free clinics, and refers to the intense energy required to concurrently keep your "agency" going, remain alert to what's happening in the community, take political actions when necessary, keep your "agency" responsive, keep your self-confidence alive in the frustration of trying to change the system, keep your personal life in some order, and maintain a little peace of mind. Since so many of these activities are crisis-oriented, most volunteers involved much at all in any alternate institution end up sometimes craving a little order in chaos, a little predictability and certainty in the immediate future. When this craving becomes overwhelmingly irresistable, "burn-out" occurs, followed shortly by dropping-out and going somewhere else, frequently to the country. "Burn-out" explains why the turnover in many alternate institutions, especially free clinics, is so high. Even though most clinic coordinators get paid after the clinic has been going awhile, it is still barely enough to live on. No one in the Ann Arbor Free People's Clinic has ever been paid in the year and a half it has been open. A few weeks ago each of the clinic coordinators was voted an annual salary of $4000. For full-time work where "full-time" means upwards of 60 to 70 hours a week, that's an incredibly small sum.

PART II. How Things Work Out in Practice

SECTION D: Why People Go to Free Clinics

Young People

Those people who seek services from free clinics are called "medically indigent" by clinic people, but the term means more than just "free clinic patient," and certainly includes more people. The medically indigent are people who, for whatever reason, cannot or will not obtain treatment at an established health facility. The "cannot" refers to economic and racist barriers, the "will not" refers to sexist, emotional and psychological barriers to treatment.

Not all young people who seek assistance at free clinics are alienated youth. Many males have hair which is only stylishly long and many are quite conventionally dressed; no one would refuse them treatment as "freaks" or "hippies." But many come simply because they are seeking treatment which is provided in an atmosphere consistent with their life-styles and values; that is, they are looking for warm, personal treatment where they are treated as if they have a right to know what is going on, what is happening to them and why. Adolescents in this society are too often expected to blindly respect and obey authority, since adults always know better (they have experience on their side); from parent to teacher to doctor, the attitude is fairly consistent.

But there has been a new attitude developing among the young, especially, towards authority. The experience which adults have always cited is no longer relevant to young people; too many things have changed too quickly. The impact of accelerated technology on our daily lives has probably endowed the experience of the young with more validity in predicting the future than that of their elders. And young people feel this, though they may not be able to express it.

This is why authority which cannot explain and justify its decisions, which relies on tradition and blind obedience, no longer receives much respect from young people; and why many young people who are not "counter cultural" in appearance, rhetoric or apparent life-goals seek help from institutions born of the counter culture (whether born of its own need for help or as an expression of its belief in human values).

Even young people with access to free care in a university health service come to free clinics, where the primary attraction of the free clinic is its attitudes and its atmosphere.

There are other young people who are not necessarily alienated from society who seek treatment at a free clinic because they have socially stigmatized problems. VD, birth control information and devices, problem pregnancies -- all these are problems and concerns of youth which the medical establishment in particular, and the dominant culture in general, has not dealt with honestly, openly, and compassionately. Most young people who come to free clinics for sex-related problems do not view the clinic as their primary health unit, and most of them will never return unless they have the same problem again. But the necessity for their finding treatment in a free clinic only reinforces the fragmentation of services and destroys whatever continuity of care they may have with a family doctor.

Neighborhood People

Community residents seek treatment at a free clinic the first time, because it's conveniently located, has convenient hours, and it's free. They come back because their questions are answered and more; because the staff is gentle and kind; because it's a cheerful, friendly place to be; because they also get drugs, which means they get well.

It is more likely that a neighborhood free clinic will become perceived as a primary health care unit than a street clinic, mainly because the population is stable and people get to know one another. One of the patients I talked with at the Baltimore clinic, an elderly unemployed man from the neighborhood, said he first came in because he needed a physical for a job he was trying to get, and the clinic did it free. But the doctor found some things wrong and suggested the man come back; he did, and has been coming in ever since. This man knew all about the clinic and how it worked, the services it provided and why - all of which he had learned from the staff. He was enthusiastic about the volunteers, and as he talked, told me to be sure to "put it all in your report."

The Baltimore clinic waiting room, on the night I was there had an interesting bi-racial mix of neighborhood people- several elderly men and women, a couple of housewives, a young couple with two children, several young women with a little girl, a couple of high school students, several male "freaks," several middle-aged women, a middle-aged man, a cat, a teenage boy....

PART II. How Things Work Out in Practice

SECTION E: Clients

There are no typical free clinic patients. They come in all sizes, shapes and colors, ages, cultures and creeds. Some generalizations can be made, but exceptions are the rule.

Free clinics see from 6,000 to 60,000 patients each in a year. H.E.A.D. Clinic (New Orleans) sees about 30 a night; Southside Medical Center (Minneapolic) tries to limit its patient load to 20; Long Beach Free Clinic (California) sees about 40 to 50; Baltimore People's Free Medical Clinic sees about 30 to 40; Washington Free Clinic (Georgetown) sees about 40 to 65.

Since street clinics deal primarily with young transient youth, their patients are slightly less heterogeneous than neighborhood clinics; youth clinics have the most homogeneous clientele. The bulk of street clinics' patients fall into the 19 to 24 year old category, with 16 to 18 a close second, and 24 to 28 a close third. They are generally white and come from middle-class families, although "middle-class" seems to be less and less distinct. Although they still bring in drug problems, that too is decreasing, while VD seems to be increasing. The demand for general care is constant, as for first-aid type treatment for cuts and burns, young women seeking birth-control information and devices, and help with problem pregnancies and abortion, and prenatal care.

Neighborhood clinics see everybody and for almost everything; their age reange is from 5 days to 86 years. Most neighborhood clinics serve a particular community, so that the patients are mostly black, mostly Chicano, mostly Chinese, mostly whites of Appalachian origin, mostly American Indian, most Puerto Rican. . . . The needs of the community usually cover a wide range of problems because the previously existing medical facilities were sufficiently inaccessible that few people in the community have had good continuous care.

PART II. How Things Work Out in Practice

SECTION F: Decision-Making

To isolate and describe decision-making in free clinics is extremely difficult. There are a few consistent patterns, but not many. Nearly all clinics try to develop community participation in decision-making, but this has been less than successful. Most clinics experiment with one approach for a while, then try another.

Some clinics have a Board of Directors which makes policy; composition of this Board can run from people (usually professionals) who do no work in the clinic at all to elected representatives from clinic staff and patients. Other clinics take policy decisions to a completely open meeting where those present - whether staff, patients, or interested individuals - make the decision. This may be by majority-rule voting procedures, or by total consensus.

In some clinics medical policy and operational decisions are determined by the regularly scheduled staff of that night. The Washington Free Clinic in Georgetown, for instance, has some nights where the medical approach is team practice and other nights where more traditional medical hierarchy is retained; each has been decide upon by the staff. Where clinics are organized by nights and have policy-making boards, representatives are elected to the board by nights; it would not be impossible to have 3 nurses representing, say, the Monday, Tuesday, and Thursday staffs, and no doctors.

More common, however, is organization along service areas, so that where there are policy-making boards, there may be elected representatives of counselors, lab technicians, nurses, medical students, doctors, etc.

This far in their evolution, there seem to be three categories of strong distinction among free clinics, whether they use the open meeting, the representative Board of Directors or some variation thereon. Descriptions of professional-based, community-based and collective types follow, with specific examples later on.

PROFESSIONAL-BASED FREE CLINICS

Professional-based clinics are essentially dominated by the volunteer professional staff, who more or less make all the policy decisions of the clinic as well as determine how the clinic will be run; this approach is usually regarded as "elitist" by clinics of the other two types. Professional domination may be structured into the clinic's decision-making framework, by establishing the Board of Directors as the effective decision-making body of the clinic where the Board of Directors consists of professionals from the community, or of professionals elected from the volunteer staff. The clinic may be dominated by professionals in a more informal way, where a few professionals simply take charge--sometimes on the strength of their personalities, or there may be one person in particular--sometimes the founder, or chief fundraiser. The clinic may have an older administrator whose orientation is toward the professionals, or the professionals in a clinic may simply have the ability to block any decision which they oppose from being enacted. This situation is more likely in street clinics, where the "community" being served is largely transient and therefore difficult to define, much less integrate into the decision-making process. The Haight-Ashbury Free Medical Clinic is generally regarded as a professional-based street clinic, while the Teenage Medical Service in Minneapolis is a professional-based youth clinic. This description is not meant to imply that these clinics are any less flexible or responsive than any of the other free clinics, simply that this responsiveness is more dependent on the attitudes and behaviors of the professional staff than in other clinics.

COMMUNITY-BASED CLINICS

Community-based clinics attempt to put decision-making powers in the hands of the staff, both professional and non-professional, and the patients. Policy is usually decided at well-publicized open meetings, or the Board of Directors, if it is the effective decision-making body, has patient representatives or community members, as well as both professional and non-professional staff as Board members. Frequently there is some combination of the two arrangements. Operational decisions may be made by clinic coordinators who are usually young people (whether it is a street clinic or a neighborhood clinic, this seems to be the case) whose bias, if anything, is away from the professional. Community-based clinics feel a need to

prevent professionals from dominating the clinic or having much power over decisions - both operational and policy - since the feeling is that it has always been the insensitivity of the professionals to human needs which has created the bureaucratic impersonal, profit-oriented medical system we live with now, and that the people to whom the service is given should decide how that service will be rendered.

In actual practice, while community-based clinics generally have a more open framework of decision-making, they have great difficulty in getting non-staff people to attend meetings and take an active role in developing the clinic. As several people said, "It's hard to organize people around health - they don't think about it until they need treatment, then, they don't want to hear about the clinic or volunteer to work, they just want to feel better!"

Where nonprofessional volunteers recruited from the streets have perceived themselves as patient representatives and behaved as such, street clinics tend to have less difficulty with professional domination. The Washington Free Clinic in Georgetown is a community-based street clinic, and the Baltimore People's Free Medical Center is a community-based neighborhood clinic. The Ann Arbor Free People's Clinic is community-based, and completing a transition from street clinic to neighborhood clinic; this process is not uncommon, for as word spreads via the grapevine that there is a place to go for good, personal, free care, street clinics are beginning to see more of the alienated than just young people.

COLLECTIVES

The collective approach is an attempt to equalize responsibility for and deprofessionalize the running of the clinic itself. Either all the staff - both professionals and nonprofessionals, or a portion of the staff - usually the nonprofessionals, live together in one housing unit and share a monthly allotment from the clinic for all living expenses; the money may be divided up equally or it may be apportioned on the basis of collectively-determined need. Or the group may simply meet together on a regularly scheduled basis as a work group or a study group of some sort. This group shares responsibility for all aspects of their free clinic's operation.

This arrangement is rather rare, and I did not visit any or talk with anyone from one. I have been told that one clinic tried paying each and every person on the staff, from the receptionist to the physician, the same subsistence level salary, but "it didn't work out."

EXAMPLES

H.E.A.D. Clinic (New Orleans)

H.E.A.D. Clinic in New Orleans was until recently an interesting combination of all three approaches. The clinic serves primarily young transients, especially because the French Quarter is the first stop for young southerners intending to split for California. On the second floor of the building in which the clinic is located is the clinic and N.O.S.E. Switchboard, which attracts a large number of young volunteers. On the third floor lives the Household, a collective of rom 3 to 6 young people who act as H.E.A.D. and N.O.S.E. coordinators on a rotating basis. Rent for both floors is paid by the Board of Directors (which is the same for both the clinic and switchboard). The Household is alloted $120 a month for all needs of however many people are living there at the time - food, clothing, travel, etc. Needless to say, most members work elsewhere at least some hours a week. Because the Household is directly accessible to both the clinic and the switchboard all hours of the day and night, Household members find themselves making virtually all operational decisions, and solving all crises, which in some cases amounts to making policy decisions. On this level, the clinic and switchboard are run as a collective, rather "family"-style, yet the Board of Directors is heavily dominated by professionals, both medical staff and professionals from the city who maintain rather tight control of the clinic and switchboard, especially when it comes to taking public stands on issues, starting new programs or changing existing ones. Because of the psychological and emotional drain of effectively being "on call" 24 hours a day, with no real privacy, the Household quite recently disbanded and together with N.O.S.E. volunteers is pushing for a restructuring of the decision-making process in the clinic to include more patient feedback and greater community control.

The Ann Arbor Free People's Clinic (Michigan)

The Ann Arbor Free People's Clinic has recently developed a new arrangement because the previous approach had broken down almost completely. Under the old approach, a Board of Directors composed of one elected representative from and by each of the services (doctors, medical students, nurses, counselors), and six patient representatives who had elected four of themselves at an open meeting and reserved the two openings for future input, was responsible for all policy decisions. The Board theoretically met

every two weeks, but was usually unable to produce a quorum. Operational decisions were made by two unpaid clinic coordinators, and medical policy was left up to individual doctors. In practice, all decisions fell to the two clinic coordinators and any disputes over medical policy were resolved by the passage of time. The coordinators began to push for changes in the effective decision-making process, since they were drained by total responsibility for the clinic, and concerned that the clinic was becoming elitist. Subsequently, during large meetings of most of the clinic workers and some patients last Spring, a new decision-making framework evolved. To avoid the legalities involved in changing the Board of Directors, a Coordinating Committee was established to make policy decisions. This Committee is composed of 13 people, five of the original Board members who felt they could afford the time, newly elected representatives from each of the service caucuses not represented by a Board member, the two clinic coordinators, and the remainder patients. Presently, there is only one patient on the Committee, but the clinic is holding an all-clinic, all-community meeting in September to discuss the new structure and decide on procedures for adding more patients. September was chosen because of the usual lull in activity during the summer months in a University town. The Coordinating Committee is responsible for <u>all</u> policy, meets every week to discuss health issues and clinic events, and makes policy-decisions at every second meeting. By a majority of vote of the Committee, policy votes can be thrown open to the entire meeting. Operational decisions are still the responsibility of the clinic coordinators, but when they feel that a decision effectively involves policy, they now have a group to take the decision to for ratification or rejection.

<u>Washington Free Clinic (Georgetown)</u>

The Washington Free Clinic in Georgetown has a system somewhat similar to H.E.A.D. Clinic. There is a 5-member collective which takes care of all the operational decisions (supply-buying, administration, correspondence, as well as cleaning up and setting up, and providing the clinic with some continuity). Unlike the H.E.A.D. Clinic, however, policy decisions are made by an open meetings of all volunteers, both professional and noncredentialled, and any one else who want to come; it is held twice a month. Decisions are made on a consensus rather than majority basis, usually by someone's finally saying, "Does anyone object if

we do thus and such?" Although one would think this a rather intimidating method of obtaining a consensus, in actuality people do speak up. Bob Rosen, one of the collective members, said he thought the process worked fairly well, though it is time-consuming.

Baltimore People's Free Medical Center

The Baltimore People's Free Medical Center has a similar framework for decison-making, but also holds staff/patient meetings after every clinic night to discuss whatever problems may have arisen during the evening; resolution is either made at the meeting or deferred to another, better publicized policy meeting.

The open meeting to which anyone may come is the most consistent feature of free clinics. Variation arises over who is eligible to vote (if voting is part of the procedure) and what the open meeting has the power to decide. Of course, successful implementation of those decisions is also dependent on the staff, who may or may not respond.

To reach any definitive conclusions with respect to the effectiveness of this style of decision-making, more thorough research would have to be undertaken.

In most youth clinics all decisions are made by the professional staff. Teenage Medical Service (Minneapolis) admits this as one of their most often criticized features, and is concerned about developing an approach to provide greater patient input.

Free clinics have not really been able to solve the problem of decision-making falling into the hands of whoever has sufficient time to do the work or remain informed. They have been more successful in opening up the decision-making process to a broader base of participation than is usual in service agencies. Most clinics, however, haven't been in existence long enough to have worked their way through a number of approaches. The process is tedious because there really are no successful models available anywhere. I suspect that as time goes on and clinics mature, their decision-making processes will become progressively more democratic, but concurrently more time-consuming. It will be an interesting evolution to watch.

Section G: Costs and Funding

Because their funding bases are so precarious and their sense of commitment to the needs of the communities they serve is so high, most free clinics parlay their available resources into an astounding amount of service. The average cost per patient visit, which includes services from general medical attention to counselling and psychological help to diagnostic lab tests, runs from around $1.00 at the Los Angeles Free Clinic to a high of about $12.00 at the Teen Age Medical Service in Minneapolis. Most clinics seem to average around $3-$4 per patient visit; this is true of the Baltimore People's Free Medical Clinic as well as the San Antonio Free Clinic. Somerville Women's Health Project (Mass.) and H.E.A.D. Clinic in New Orleans each spend around $1.50 per patient visit. Hollywood-Sunset Free Clinic (L.A.) spends about $2.00 per patient visit. Harbor Free Clinic (San Pedro, Calif.) spends about $5.00 a patient visit, and the county-run (sponsored) free clinics in Los Angeles spend about $6.00 per patient visit. It is fairly obvious that free clinics are providing a vast amount of medical care and service for surprisingly small amounts of money, yet money is still quite difficult to acquire. (See Attachment B for example budget breakdown for a free clinic.)

Free clinics manage to exist in a variety of colorful and creative ways. Exceedingly few clinics have any steady source of income large enough to provide a sense of security. At present their financial standings range from thousands of dollars in the red (with no salaries having been paid for months) to an estimated two to three months nest-egg in the bank. Free clinics live virtually hand to mouth.

Clinic budgets range from $6,000 to $60,000 a year, with most falling around $20,000 to $30,000. Personal donations rather than grants seem to provide the major portion of clinics' operating cash. There are, of course, donation cans in the clinics' waiting rooms with posters enunciating the need for financial support and asking for anything the patient can give. Some posters include the cost to the clinic of providing specified lab tests or a financial breakdown of the clinic's budget for the current month. Clinics usually receive from $50 to $600 a month this way. Some clinics have cans and jars on the counters of friendly business people (usually these are street clinics and the businesses cater to young street people). Some of the better-known clinics like the Los Angeles Free Clinic or neighborhood facilities like the Baltimore Clinic receive

personal checks or cash in the mail with letters saying, "I heard about the good things you're doing -- keep it up!" The Baltimore People's Free Medical Clinic has devised a system where individuals or families in the community pledge $2 to $5 a month; community support is strong enough that the clinic usually receives $350 to $400 a month from this source.

California clinics seem to be the only ones who do panhandling; volunteers -- sometimes appreciative patients -- at the Long Beach Free Clinic are skillful enough at spare-changing that the clinic generally sees $1,000 to $1,500 a month of the man-in-the-street's money. Some clinics are reimbursed by the county health department for each VD patient they treat (the Ann Arbor clinic receives $7 per patient), but this is far more likely to come in the form of drugs for treatment than cash.

Some clinics have finagled small grants of $1,000 to $2,000 from organizations like the United Fund, the Community Chest, and other service organizations. Some have gotten small grants of $5,000 or $10,000 in order to get started from local foundations; this frequently happened when the clinic was the first in the area and was considered "innovative," or was beginning a new program.

Clinics have held benefits, movie premiers and radio marathons to raise money. H.E.A.D. Clinic in New Orleans sends volunteers to clean out people's attics and garages on the condition that the contents are donated to the clinic. The volunteers then cart it all to a clinic "flea market" in the French Quarter where all proceeds return to the clinic. The local bubblegum machine distributor has agreed to donate a percentage of the profits to H.E.A.D. Clinic of any new machine which clinic volunteers can persuade a business to accept; this, however, has not yet been profitable since few volunteers have gone out to local businesses.

Churches are another source of funds, though more frequently they donate rent-free space for location of the clinic (space is usually in the basement. Washington Free Clinic in Georgetown has this arrangement). The Catholic Church almost totally supports El Barrio Free Clinic in Los Angeles. Joint Urban Mission Project, a council of four area churches in Minneapolis, has donated several thousand dollars to the Southside Medical Clinic there, which also receives about $5,000 in a drawing account jointly funded by Northwestern Hospital and Model Cities.

Some hospitals seem to be becoming interested in assisting free clinics; as mentioned previously, this may be because free clinics protect them from having to deal with poor and culturally different people, where free clinic people feel that they have had a consistently miserable record. A more charitable view is that hospitals are concerned with helping free clinics continue to provide services that they were never able to accomplish. In any case, this is one possibility for some funding that free clinics are beginning to push on.

GOVERNMENT FUNDING

The recent NIMH-SAODAP grant to the National Free Clinic Council was the beginning of an attempt by some people to find national funding for clinics, and so develop a more secure funding base. Because of the controversy surrounding this grant, several points have emerged. Many clinics rely on the diversity of their funding sources to maintain their autonomy; this also necessarily means that grants must be small, so that the clinic can continue to function even if any one or two sources retract funding because they disapprove of a clinic's actions (usually political-taking a public position in a controversy, or attacking a local medical institution for failure to live up to its responsibilities). A large number of clinics are not interested in "drug abuse" grants because they feel that:

1. More than just street drugs are involved in drug abuse; caffeine, nicotine, alcohol and prescription drugs are abused in the homes of Americans everyday.

2. Drug abuse prevention must involve more than simple education and seminars; it must assist the individual to develop a satisfactory way of life without drug dependence.

3. Drug abuse in this country is merely symptomatic of the distressing societal conditions which prevail; until these are changed, drug abuse will continue.

4. Concentration in drug abuse diverts too much energy and too many resources from more pressing health problems.

5. No "drug abuse" grant involves recognition of any of the above conditions; therefore, the strings attached to a "drug abuse" grant make it impossible to do anything genuinely effective about the problem.

Further, many (but not all) clinics are skeptical of Federal Government grants, seriously questioning the ability of the government to let clinics handle grants in a style consistent with their values. They are concerned over Government access to patient records, particularly through GAO audits. They don't want the resource drain of accounting systems and reporting requirements, much less having to keep statistics and possibly having to hassle patients over eligibility requirements. This is precisely who so few clinics have pushed for Medicare, Medicaid, and welfare reimbursement; those few which have done so have been able to devise a simple system, and of course don't receive all they are entitled to.

David Smith of the NFCC raises the objection that Government grants, because they are categorical, definitely fragment services rather than coordinating and integrating them. He speaks from experience, as the Haight-Ashbury Clinic is presently operating under an NIMH grant for drug abuse, primarily hard narcotics, but can't provide dental treatment (something which many addicts desperately need) under the grant; yet the increased need for that service has been partially generated by people coming to the clinic for treatment under the grant.

Some clinics, especially street clinics, feel that Federal funding is undesirable if for no other reason than that it might jeopardize the clinic's legitimacy in the eyes of the community it serves. Young people alienated from the system are not likely to seek help in the camp of the enemy (which they perceive the Federal Government to be). Other communities, especially working-poor communities, might begin to view the clinic as a "charity clinic," somewhat akin to being on welfare; this objection was raised by Mary Nudell of the Southside Medical Clinic in Minneapolis which sees many working-poor and has been asked whether it's a Government charity clinic by some of its patients.

On the other hand, many free clinics cannot find adequate funding because vested interests in the political and/or medical establishment on a local level find their existence threatening, and because in many localities health care for the medically indigent is not a priority. In many localities, available funds for health services to the medically indigent are taken up by more traditional agencies with more traditional approaches. Some clinics feel that Federal funding would enable them to by-pass these problems,

and would free a great deal of energy spent on "bread hustling" for more creative and positive uses in delivery and improvement of health services (e.g., as previously mentioned, more outreach work, more educational programs, more preventive care).

While free clinics will probably continue to live hand-to-mouth, their present form of funding is a primitive form of wealth redistribution, but a very insecure one.

Section H: Southern California Council of Free Clinics

There is only one regional consortium of free clinics, the Southern California Council of Free Clinics. Because the earlier clinics were concentrated on the West Coast, and even today there are more clinics in California than in any other area, it was natural that these clinics, in close proximity to one another, develop the first area coalition.

In July of 1970, a State Regional Medical Programs grant of about $22,000 provided financial backing for the establishment of an office and four staff members, called "The Free Clinic Liaison Program," the grant enabled the first council meeting to take place in August. The idea had been discussed among the clinics for several months, and its realization was due to the efforts of four or five people involved full-time with free clinics in Los Angeles and one person on the RMP staff. The clinics originally intended to work together in order to obtain larger grants, but it eventually became clear that large grants caused more problems than they were worth.

The first grant the Council obtained was from Economic and Youth Opportunity Agency of Greater Los Angeles (EYOA), a State OEO agency. Because EYOA had never funded any programs for poor whites, (political) pressure was exerted on them to fund the Council. A grant of about $87,000 was made to the Council in March 1971 for development of community organizing and the institution of poverty programs through the free clinics. The grant supported a field staff of eight workers, each assigned to two clinics in Los Angeles County, and a core office staff of four.

But soon problems began to develop. EYOA and the Council could not agree on hiring policies, or on target populations. The clinics and the field workers finally concluded that EYOA's interference and rigidity made accomplishment of the grant's objectives virtually impossible. On August 26, 1971, the Council presented EYOA a letter cutting off all relationships between the Council and EYOA, and further refusing all future funding from EYOA; at the same meeting, EYOA subsequently took the Council into receivership (which took all decision-making power into EYOA). At that time less than half the grant had been spent.

This experience certainly did nothing to enhance the prospect of government funding in the eyes of free clinics; in fact, for many people it only confirmed what they had

suspected all along, that government was rigid, unresponsive to the needs of human beings, and more concerned with the letter than the spirit of its guidelines.

The council managed to limp along on what was left of the old RMP grant (which had no time limits on it and was extremely flexible money) plus $2,500 from the Adolph Foundation, until February of 1972, when it received a second grant from the State RMP for establishing medical standards in the clinics and evaluating the free clinics' services. It is presently operating under this grant, which terminates in December.

There are currently around forty-five members of the Council representing the seven counties of Southern California. The Council includes a number of associate members - other social agencies involved with and interested in free clinics, e.g., crisis intervention centers, hotlines, community organizations such as Gay Community Services Center (which will achieve full membership when they open a free clinic next month); associate members do not vote, but serve on committees and participate in meetings.

The Board of Directors is the entire incorporated body of the SCCFC, which meets quarterly (i.e., each member sends a representative). The Board sets general policy, provides accountability for all funding, and is the ultimate decision-making body of the Council; it ratifies or rejects the decisions and directions set by the Coordinating Council.

The Coordinating Council is the working group of the SCCFC, and meets at least once a month. It consists of the President, Vice President, Secretary and Treasurer of the Board, the chairperson of each program committee, one representative from each county council, one voting representative from the Advisory Board, the chairperson of each standing committee (Quality and Standards, Communications and Resources, Minority Rights, and Membership) and other committees as established by the Board and the Council staff.

The county councils are the structures by which free clinics and community health organizations work together on common problems, and they also meet once a month.

After the experience with EYOA, the Council decided to turn its energies strictly to information-sharing, policy establishment, and collective action. The only acceptable grants would be small, and would not be administered by

the Council staff although the grants would still formally be made to the Council. What evolved was a rather unusual and innovative procedure. A Program Committee is formed of one representative from each clinic receiving money from the grant; thus only those clinics involved in the grant administer it, and can work out mutually acceptable solutions to all problems based on the realities of the situation, rather than having an isolated administrator make decisions in a vacuum.

There is presently only one working Program Committee, that administering the Los Angeles Regional Family Planning (LARF) grant for distribution of birth control supplies. The second LARF grant which began on July 1, 1972 involved 9 clinics in Los Angeles County, and pays for the supplies plus (unlike the first one) a minimal salary for a full-time coordinator. The total grant is $17,000.

The Council is presently engaged in two major areas. The Resource and Communications Committee is developing plans for a newsletter, and is tackling the issue of resource-sharing - especially drugs and equipment. Frequently, a clinic must turn down an offer of equipment - examining tables are frequently proffered, sometimes an x-ray unit - because the clinic doesn't need it and there is no place to store it. Then two months later a new clinic opens up or another clinic for some reason would like the equipment, but it's no longer available. The Committee is presently looking for a warehouse to use in storing equipment and surplus drugs as well, and is considering the possibilities of collective supply buying in the future.

A major controversy is rapidly developing over abortion services and reported unethical practices. Recently liberalized interpretation of California's abortion law has meant a dramatic increase in hospital-performed abortions.

Since hospitals cannot "advertise" their services, they are dependent on abortion referral services to form the link between patients and themselves. Many free clinic people, particularly women involved with women's clinics, feel that hospitals are making "quick profits" by charging high prices (about $150 for a 3-4 hour hospital stay) for minimum medical care with no additional counseling or psychological care; they charge that many hospitals are little more than a mass production line, with little warmth

or compassion for the woman involved.

Further, many hospitals are reportedly paying "kickbacks" to referral services on a per-patient basis; this has established a situation where patients are referred to hospitals on a profit-making basis for the referral service, rather than on a quality of care basis for the patient.

Because free clinics themselves do a large portion of abortion referrals, they are a potentially loud, autonomous voice in the struggle to "clean up" and humanize services associated with abortion all the way down the line.

Late last spring a Los Angeles hospital began approaching individual local clinics, attempting to develop an exclusive contract with each clinic for abortion referral in exchange for doctors, cash, supplies, or whatever else the clinics desired. Alarm among the clinics mounted as it began to seem that this hospital was trying to "buy off" potential clinic intervention in its abortion "program."

At the Council meeting in June, free clinic people present were able to quickly agree that collective action was both necessary and important. They appointed the administrator of the Women's Clinic (Los Angeles) to represent them in all negotiations with the hospital; inquiries from the hospital to any clinic will be directed to her. They further established a committee under her to work on the problems with the entire abortion situation -- from referrals to medical procedures to counselling.

The clinics in Southern California have found the Council to be an invaluable vehicle for pooling of information and sharing of resources, for ironing-out of problems, and taking collective action on issues which affect them all.

Section I: The National Free Clinic Council

The National Free Clinic Council was established in 1968 largely due to the efforts of Dr. David E. Smith, founder of the first free clinic, the Haight-Ashbury Free Medical Clinic (June, 1967), early spokesman and interpreter of free clinics to the Establishment. The NFCC stated as its goal "....to overcome the crisis orientation of most of the currently operational free clinics... (to) permit the necessary expansion into all primary health care services." (See Attachment C for the NFCC Statement of Purpose). It offered its operational objectives as:

1. To provide a focal point for the sociomedical momentum of the free clinic "movement."

2. To develop a system of information dissemination concerning all aspects of free clinic operation.

3. To gain access to health care funding which is available at the national level and distribute such monies equally to member free clinics.

4. To sponsor and administer an annual National Free Clinic Council Meeting.

5. To provide consultation services both for improvement of quality of services being rendered in established free clinics and for establishment and organization of new free clinics.

As the free clinic movement grew, so did the activities of the Council. It sponsored a Free Clinic Symposium in January, 1970 with some 25 clinics participating. In January, 1971 the Council held the first NFCC Symposium with about 500 individuals present, and the Second Symposium in January 1972 had over 800 registrants. But at the recent Second Symposium, one of the most violent controversies ever to shake the free clinic movement, ripped through the conference and shattered it, leaving free clinic people everywhere wondering what happened. That controversy is still raging. An excellent and penetrating account of that weekend is available elsewhere (See Health-PAC Bulletin No. 38). What emerged from the weekend is that many free clinics at the present time do not stand behind the National Free Clinics Council's attempt to obtain Federal or any other kind of national financing. Already many clinics have stated their intention not to have anything to do with the NIMH-SAODAP drug abuse grant (exactly how many is impossible to tell, but conversations with people from Ann Arbor, Baltimore, Washington, New Orleans, Los Angeles and several

Minneapolis clinics have made it crystal clear). At the March Medical Committee for Human Rights Convention in Chicago there reportedly was talk of forming an Amerikan Free Clinic Council to block all actions of the NFCC, but those people present decided that their energies would be better spent in their clinics.

The most immediate cause of dissension within free clinics has been the $1 million NIMH-SAODAP grant, but the roots of the debate go much deeper than that. Many free clinics feel that the NFCC has compromised their principles and philosophies all the way down the line, and the $1 million drug abuse grant is symptomatic of the NFCC's approach to its stated goal of "the attainment of national legitimization (for free clinics)." To many free clinics the grant is the beginning of making free clinics a "legitimate" part of the medical establishment by allowing the existing health care delivery system to continue as it always has and providing free clinics the permanent and perpetual function of "cleaning up the leftovers," of forever remaining band-aids on a fundamentally sick system.

This approach directly contradicts many free clinics' perception of their function as the provision of health care to the medically indigent only until they have succeeded in changing the present system sufficiently to adequately provide good health care for all people.

The other side of the argument, however, rests on a less optimistic view of institutional capacity for change. Implicit in the search for more stable sources of funding is the feeling that "if we don't provide it, nobody will, and then once again our people will have nowhere to go."

There is a very fine line between attaining sufficient legitimacy to have some impact on the system, and institutionalizing oneself as the band-aid solution to the system's failures. Some free clinics feel that the present NFCC approach will push the movement over it, into institutionalization; others do not.

Because of this deep disagreement, many clinics are concerned that the NFCC will assume the role of spokesman for the entire movement. This fear is not unfounded since the NFCC is the only national "organization" of free clinics. (Similarly, although the AMA does not speak for all doctors, it has assumed the role of spokesman

for the medical field, partly because other people have treated it as such.)

Other objections raised in free clinics against the NFCC include the fact that it is not now and never has been a representative body; no elections have ever been held for regional representatives or for the executive positions, and the constituency has never agreed to be represented by the NFCC (i.e., no clinic has ever "joined" the NFCC). On these grounds, how can the NFCC call itself a spokesman of the free clinic movement? Further, in direct contradiction to the goal of de-professionalization, the NFCC was formed almost exclusively by professionals with no input from the community or from noncredentialed health workers. The overloading of degreed professionals on the Conference agenda in January demonstrated a continuing bias in favor of professionals, whose attitudes are perceived by many free clinic workers to be a significant source of the problems which generated free clinics in the first place. Again, how can the NFCC be representative of the free clinic movement?

Presently there is discussion among some free clinics of ways to convert the NFCC into a representative, viable organization, and to establish new priorities. A constitutional convention is being planned for February 1973, and discussion concerning elections for all positions is underway. Whatever else emerges from the controversy, one thing is quite clear: at present, the legitimacy, aims, direction, and personnel of the National Free Clinic Council stand in serious question among a large number of free clinics. This controversy crystallizes the philosophical dilemma which many free clinics find themselves caught in: how to make the transition between this system and a better one.

PART III. RECOMMENDATIONS FOR ACTION

Because free clinic people have been working with medically indigent communities on a daily basis, discussing their needs and experimenting with programs and approaches to meet them, the staff of free clinics have developed an expertise which few people possess. Particularly sensitive to the actual availability of health care in their areas, many of them have developed an excellent working knowledge of health services at the functional level. Their unique position in the community gives them a perspective which few health administrators and policy-makers have.

With the present crisis of performance in the health care area (as in many other institutions), free clinic people form a vital link with unmet health needs in the community which all institutions genuinely concerned with effective health care delivery cannot afford to ignore. The importance of the free clinic approach has been established overwhelmingly by the acceptance and use of services, by community support in times of harrassment, by community people volunteering to work in clinics, by the constantly increasing number of free clinics. With incredibly limited resources, they have succeeded in doing a job at which the medical establishment, with all its billions of dollars, advanced technological equipment and highly trained personnel, has been less than successful. Quite clearly the difference is in approaches to health care. HEW spends millions of dollars in developing health care programs to serve unmet health needs. It needs free clinic people. Dialogue between HEW and free clinics must begin.

1. Informal discussions with free clinic staff, supported by on-site visits to free clinics during the evenings when they are operating, would serve to inform health program administrators of the free clinic approach and its success. This should happen for both top level administrators and regional office program administrators, as well as program officers.

2. Free clinic workers, especially those in clinics which have specified as their task the establishment of programs and systems to fulfill unmet health needs, should be placed not only on advisory committees and guidelines committees, but also on intradepartmental committees established to design or evaluate programs, and should

become involved in the grant reviewing process. For example, there is no reason why staff people from free clinics should be excluded from the health service committee drawing up guidelines on consumer self-health programs. Free clinics have proven that "technical competence" and a host of credentials are not as relevant to insight on health needs and approaches to meeting them, as are genuine concern and constant interaction with the community.

3. HEW should use its considerable influence to exert pressure on State and local government in several ways.

a. Free clinic staff should have input into State health plans; where those are operational, free clinic staff should assist in evaluating them.

b. More varieties of people should be included in State health planning agencies; HEW may require that position descriptions be written and strongly suggest that experience working in a free clinic is especially valuable. Health planning needs to involve more skills than statistical analysis and administrative facility; it needs to involve first-hand experience with the needs to be met.

4. HEW should use its influence with medical schools to exert pressure for changes in those institutions.

a. More minorities and more women should be admitted and assisted financially.

b. Curricula should be more flexible in health professions institutions; more first-hand experience in the community is needed by health students in all fields.

(1) Few medical institutions have even been responsive to dialogue initiated by free clinic people. The University of Minnesota is a notable exception.

(2) Because the socially accepted way of seeking help in this society is to seek out a doctor, many people bring more than simply medical problems to a doctor. While societal change in these attitudes is an ongoing process, health students, especially medical students, need more training in sensitivity to and ability to deal with these problems, particularly sex-related problems; doctors need to develop an ability to treat the whole person rather than just his/her disease, and to handle referrals in a sensitive and compassionate manner.

Health professions curricula should be altered to meet this need.

5. HEW should also use its influence with State departments of education and local school boards to emphasize the necessity for sound, thorough and serious attention to health education. The present state of health and nutrition education in the schools is scandalous. Free clinic people are excellent resources to provide assistance in this area. They have proven an ability to communicate effectively with young people; many have successfully written their own literature to relate desperately needed information to young people.

a. With HEW support, free clinic people can work with State and local educational agencies to redesign the health curricula and literature.

b. At the minimum, free clinic people can conduct education seminars, workshops and other programs in the schools to supplement existing approaches.

6. HEW should use its influence with hospitals and public health services to ensure that free clinic people are involved in planning new programs and evaluating existing ones. Where HEW programs require community advisory boards, HEW guidelines should require free clinic representation on those boards.

7. Free clinics are serving communities which are unable to provide health care facilities for themselves. Many health programs are aimed at assisting these same communities, but administrative policies and program guidelines prevent free clinics from receiving direct HEW assistance and support. Yet free clinics have shown a measure of success which outshines many more lavishly funded organizations. HEW can and should support the improvement of free clinic services and the dissemination of their approach to health care. Policy and guidelines which exclude free clinics from financial support through HEW programs should be revised. HEW should also provide technical assistance to free clinics in developing proposals and seeking other compatible funding sources, as well as actively encouraging private agencies and organizations to fund free clinics.

8. There are many ways which HEW can support free clinics above and beyond the arena of direct funding.

a. All free clinics are legally incorporated as nonprofit agencies. The surplus property utilization program should donate property and material to free clinics which desperately need them, rather than to well-endowed institutions which already have resources to obtain what they need.

b. HEW should assist clinics to form State and regional councils similar to the Southern California Council of Free Clinics for information exchange and cooperation by providing small grants for council office staff, space, supplies and travel. It must be made clear, however, that the free clinics will control the council and its activities, and that professional credentials cannot be a requirement or an expectation of the staff.

c. HEW should assist clinics to improve the quality of their services and staff by funding training workshops, conferences and seminars to be planned and operated by free clinic personnel, with technical assistance from regional HEW personnel, especially the Youth Affairs Representative on the Regional Directors' staff.

d. HEW should assist free clinics to improve their services and to share their approaches to health problems by funding small research grants. These research grants should be carefully screened to ensure that they go to people involved in and understanding of the free clinic operation. Too often research grants are made to academics or Ph.D. candidates who have little real feeling for their subject.

e. Regional office personnel, especially the Office of the Regional Director -- Youth Affairs Representative, should assist free clinics in several ways.

(1) Assist free clinics to identify potential sources of funding for equipment and services.

(2) Assist free clinics to develop relationships with established health care institutions for the purpose of sharing information on unmet health needs and developing programs to meet local needs.

(3) Work with free clinics and local medical institutions to develop services integration models of local health care delivery systems. Free clinic people are especially crucial to this effort since they have first-hand knowledge of many of the barriers which community people face.

9. HEW and free clinics should cooperate in ensuring that HEW-funded programs accomplish what they set out to do.

a. HEW program staff should provide free clinics with policy guidelines on health programs, and notify free clinics of grants made on the local level in health services.

b. Free clinics should be recognized as social service agencies with the right to comment on environmental impact statements prepared by the Department on proposed health services grants.

As dialogue opens up between HEW and free clinics, many more recommendations for action will develop, and more potential areas of cooperation will occur. The most important of all these recommendations is that people begin talking with and listening to one another, that HEW recognize that free clinics have many vital and insightful things to say about unmet health needs, and that HEW people from top level administrators to program officers go out into the streets and listen.

FOOTNOTES

1. The Free Clinic: A Community Approach to Health Care and Drug Abuse. David E. Smith, David J. Bentel, and Jerome L. Schwartz, editors. STASH Press, Beloit, Wisconsin, 1971.

2. Free Clinics, Health-PAC Bulletin No. 34, October 1971. Page 5.

3. The Selling of Free Clinics, Health-PAC Bulletin No. 38, February 1972. Entire Issue.

ATTACHMENTS

A. Letter of April 23, 1972, from Nancy Lessin, Ann Arbor Free People's Clinic, to Ann Arbor Board of Health describing the clinic's philosophy and making recommendations to the Board for action.

B. Baltimore People's Free Medical Clinic sample newsletters, including budget breakdown.

C. National Free Clinic Council Statement of Purpose.

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April 23, 1972

Ann Arbor Board of Health
Ann Arbor City Hall
Ann Arbor, Michigan

Dear Members of the Ann Arbor Board of Health,

In your letter of March 16, 1972 to the Ann Arbor Free People's Clinic, you requested to be informed of our views regarding (1) priority health care needs in Ann Arbor, and (2) the role of the City in the development of programs to meet these needs. In order to give more complete answers to these questions, let me first describe to you the Free People's Clinic in relationship to the unmet health care needs in Ann Arbor. The fact of the existance (sic) of a Free Clinic in a town that proports to house the "finest health care resources in the world" is indicative that something is wrong with the health care delivery system in Ann Arbor. Since our opening in January of 1971, the Free People's Clinic has seen over 5,000 new patients; approximately 60% of whom live in Ann Arbor, and 85% of whom live in Greater Ann Arbor (Washtenaw County). With minimal publicity, we are now seeing an average of 35-40 patients per clinic session, or up to 200 patients per week. In order for the Free People's Clinic to continue to provide a unique health care experience for its patients and for its staff, it must maintain its philosophies and live up to its ideals which include the belief that health care is a human right, not a privilege based on income or anything else; that health care means caring about people, not just treating their diseases; that an emphasis on health education, preventative medicine, demystification and deprofessionalization of medicine must underlie all interactions between staff and patients; that no hierarchical structures can exist among staff in the clinic and between staff and patients; and that there will be no compromising of each patient's right to spend as much time getting treated and getting educated as she or he feels is necessary. But these ideals and philosophies tend to break down under the pressure of increased numbers of people needing and desiring the services of the Free Clinic. There is the fear and danger that the Free People's Clinic will become nothing more than a semi-hip out-patient department; with the high volume of patients resulting in long patient waits, rushed, depersonalized visits, and much guilt on the part of the Free Clinic workers about the inability of the clinic to meet the demand. But, because the staff of the Free People's Clinic realizes that 216 people offering medical care on a totally voluntary basis is not a really viable answer to the unmet health care needs of Ann Arbor and Washtenaw County, the Free Clinic is beginning to see its goal as not to establish the "perfect Free Clinic" but to help create systems and programs in conjunction with the established health care facilities in this town and county whereby peoples' health needs can be met. We are aware that the money, personnel, and equipment for health care is overwhelmingly owned by the already established institutions, and we feel that it is a

question of priorities how that money will be spent and which programs will or will not be set up. Traditionally, health care programs have been established by committees or groups of medical professionals who study the "unmet health needs" of a given community and then decide or advise hospitals, hospital boards, etc., on which programs and facilities they (the medical professionals) feel should be instituted to meet unmet needs. There are two such groups presently functioning in the Ann Arbor area: the Community Medicine Committee of the Washtenaw County Medical Society, and the Community Medicine Committee of St. Joseph Mercy Hospital. Both were formed to "study" the unmet needs of the Ann Arbor and Washtenaw County community and make recommendations on how these needs should be met. At the present time the St. Joseph Mercy Hospital Committee is developing a plan for a "walk-in" evening clinic that they are projecting will serve 20 patients per evening at a cost to the patient of $7 per patient visit. In a yet un-published report, a member of the committee has estimated that of the 60,000 non-student population of Ann Arbor, 1% are medically indigent; and that this walk-in clinic will be able to help meet the needs of these people. As expressed to this Committee when representatives of the Free People's Clinic met with them, the Free Clinic has developed a definition of "medically indigent" that includes people who, for whatever reason (financial or otherwise) feel they can not get the kind of health care they need and desire at the established health care facilities. We wonder how this walk-in clinic will be able to meet the needs of those who can "afford" medical care but are no longer willing to subject thmselves to the dehumanizing aspects of medical care so often found in the established medical institutions. We also wonder how this walk-in clinic will be able to meet the needs of people who can not afford medical care. We see $7 being just as prohibitive as $10 or $15 to people who have no or low incomes. $7 per patient visit will still prevent people from seeking medical attention until their problem is acute; thus will again continue to discourage any kind of preventative aspect to health care. We feel that if professionals continue to control or even dominate committees that are seeking to establish ways of meeting unmet health care needs, that the programs coming out of these committees stand a high risk of not being viable.

The Free People's Clinic is also beginning to hear more about a Community Medicine Division being established at University Hospital. One of the areas we have heard that this Division may concentrate on is the reorganization of the University Hospital Out-patient Departments to make them function more efficiently. The Free Clinic feels that any kind of long-range planning should not be in the direction of improving out-patient departments, but instead, in the direction of establishing a network of neighborhood health centers. These health centers should be located throughout the Ann Arbor and Washtenaw County area, and should be controlled by the community in which the clinic or center is located and by the health workers in that clinic. This would do two important things: (1) end dependency on traveling to a centralized hospital for health care, and (2) give consumers of health care a role in determining how that care is being delivered to them, thus making sure that the medical facility is ever-responsive to their needs.

Until such time as neighborhood health centers are a reality, the Free People's Clinic sees an increasing need for a patient-advocacy program to be set up to insure each patient who uses the Emergency Rooms, Out-patient Departments, or in-patient facilities of the local established medical institutions of their rights as a patient. While the Free Clinic has not as yet designed in detail a plan for this program, we have definite ideas on many aspects of the need for, the content of, and the institution of, such a program.

Another group or committee in the Ann Arbor-Washtenaw County area that the Free People' Clinic has been told acts in an advisory capacity, advising St. Joseph Mercy Hospital administration of the needs of the Washenaw (sic) County community and how that hospital can best be responsive to those needs, is the controversial Community Advisory Board of St. Joseph Mercy Hospital. The people who sit on this Advisory Board are:

Robert P. Laughna: Chief Executive Officer, Highway Transportation Group of American Commercial Lines, Inc., Romulus, Michigan
Howard S. Holmes : President of Chelsea Milling Company (producers of Jiffy Mix); a director of Ann Arbor Trust; a local banker
Nelson Deford : Manager of J.C. Penney's; a very active businessman in this area.
Harold Sponberg : President, Eastern Michigan University
Robert Aselson : President of University Microfilm
Ann Edwards : "homemaker"; wife of Joseph Edwards, a vice-president of Ann Arbor Bank.
Jerry Gooding : Vice-president of Whittaker and Gooding (Trucking Company), Chairman of the Board of the National Bank of Ypsilanti.
John Barfield : President of Barfield Cleaning Company
Robben Fleming : President of University of Michigan
Robert Johnson : of C.P.A. Firm Icerman, Johnson, and Hoffman; Ann Arbor's "number one accounting firm".
Paul Zimmerman : President of Concordia Lutheran College; Vice-President and director of Huron Valley National Baak.
Gage Cooper : (former) manager of Detroit Edison in Ann Arbor
Peter Forsythe : University of Michigan attorney
Keeve M. Segal : founder and chairman of KMS Industries.

It is quite obvious that these people are not at all representative of the entire community that uses St. Joseph Mercy Hospital, and would have a difficult time indeed of representing the needs of the medically indigent community of Ann Arbor and Washtenaw County. If the actual purpose of this Community Advisory Board is to advise the administration of the hospital on how the hospital can best meet the needs of the Ann Arbor-Washtenaw County community, then this present Community Advisory Board should be disbanded,as it is grossly unrepresentative of this community; and a new board should be selected by and from the total community and include medically indigent representatives as well as representatives from low-, middle- and upper-income levels.

There are other areas of health care that require immediate attention, for they have gone on too long with no attention at all: (1) There have been numerous testimonies by medical professionals and non-professionals as to the grossly inadequate health conditions in the Washtenaw County Jail, located in the city of Ann Arbor, and housing a majority of Ann Arbor and Washtenaw County citizens. As yet, these conditions remain, with no one taking the responsibility for implementing their correction. While bureaucracies continue to pass the buck, people are being deprived of their basic rights to healthy living conditions and medical care. All citizens and boards in this city and in this county should look to see who is responsible for these conditions. If it is themselves, they should undertake immediate programs and methods for correcting these conditions. If it is others, the citizens and health boards of this city should put immediate pressure and make immediate demands on those who are responsible, to have these conditions rectified at once.

(2) Laws regarding eligibility of people to receive medical treatment should be looked into at once. There will soon be bills before the Michigan State Legislature that employ the philosophy that health care is a right of everyone. This means that anyone, regardless of age, has the right to confidential medical care. All pressure should be brought to bear on those with decision-making power by citizens and by health boards and committees, to end restrictions on the rights of people to seek and obtain health care.

(3) Because of the shortage of physicians and in particular primary-care physicians, there should be an emphasis on establishing and supporting programs that utilize paraprofessionals. These programs could be, for example, in areas such as counseling: health education classes in the community and in the schools (eg. nutrition classes, pre- and post-natal classes, classes explaining cause, treatment, and prevention of certain diseases and conditions such as venereal disease, classes aimed at de-mystifying health and medical care); and screening programs and counseling for such conditions as sickle-cell anemia, lead poisoning, and poor nutrition. Such programs involving extensive use of para-professionals and non-professional man- and woman-power could be an important step in putting a focus and emphasis on preventative medicine, an aspect of health care too long neglected by many established medical facilities and institutions, and by many medical professionals.

(4) When viewing health care and health problems from a broad perspective, phenomenon such as transportation are seen as playing a vital part in contributing or detracting from an individual's right to health care. There is a great need for indigent people as well as our elderly citizens and all out citizens, to be able to have access to care when they need it. The non-existance (sic) of any kind of transportation system that can be utilized by indigent or elderly citizens plays an important part in whether these citizens have health care available to them. The area of transportation and creating a responsive transportation system should be viewed by all those interested in health care as part of the total picture of health care.

Because of the length of this letter, I will try to summarize what has been said, and then make several recommendations on how the City Board of Health can respond to our suggestions.

Problems:

(1) The major problems with the existing medical facilities in Ann Arbor include:
- -prohibitive costs of medical consultation and treatment
- -long waiting periods for medical treatment, especially in emergency rooms and out-patient departments
- -depersonalized and dehumanized treatment and care
- -racist and sexist traditions permeating much of the health care
- -poor accessibility to medical facilities (due to centralized facilities and a non-responsive transportation system or non-system).
- -no assural of patients' rights; no accountable advocacy program whereby people having problems with the existing facilities can have their grievances aired and taken care of.
- -no system of accountability to the community that uses the facilities
- -little or no emphasis on preventative health care

(2) Other health care concerns in Ann Arbor involve:
- -grossly inadequate health conditions of the Washtenaw County Jail.
- -few programs utilizing the wealth of para- and non-professionals' talents and skills
- -few programs for the community offering health education and preventative aspects of health care (including how to deal with problems such as inadequate housing, inadequate diet,...)
- -little emphasis on medical screening and counseling programs and other prevention-oriented programs in the community.
- -changing laws regarding the right to seek and obtain medical advice and treatment.

Possible Solutions:

(1) At the present time the Health Care Delivery System in Ann Arbor is not meeting the needs of many citizens of Ann Arbor. In order to assure that new programs do meet peoples' needs; programs, facilities, and systems must be accountable to those who use them. Not only should representative consumers of health care services be members and have decision-making power on all planning committees designing programs to meet peoples' health needs; but, representatives of the community that present medical facilities are now serving should have input on how those facilities are or are not meeting their needs and what should be done to rectify situations that have arisen.

(2) Programs dealing with long-range plans for the Health Care Delivery System in Ann Arbor and Washtenaw County should plan for a network of neighborhood health centers rather than "bigger and better" out-patient departments.

(3) a patient-advocacy program should be established for all people using health facilities in Ann Arbor.

(4) A seventh Public Health Nurse should be hired to fill the vacancy of the nurse who recently resigned.

(5) the priorities for spenditure of monies by hospitals, committees, councils, and boards, should be toward meeting unmet health needs. This would include monies to be appropriated for covering the costs of medical consultation, treatment, and medication for those unable to afford health care.

(6) Programs emphasizing preventative health care (health education classes, medical screening and counseling programs, etc.) should be established and funded. Skills and talents of "community people" - paraprofessionals and non-professionals - should be utilized extensively in these areas.

(7) a new, responsive transportation system should be established

(8) Health conditions in the Washtenaw County Jail should be corrected immediately. All pressure should be brought to bear on those who are responsible for the grossly inadequate conditions.

(9) Pressure should be placed upon the State Legislature to pass laws ending restrictions on the seeking and obtaining of medical advice and treatment.

(10) In light of the facts that: the Ann Arbor Free People's Clinic is now attempting to meet some unmet health needs of citizens of Ann Arbor and Washtenaw County; that the Free Clinic staff consists of 216 workers who all volunteer their time and services in many capacities in an attempt to meet these needs; that the Free People's Clinic is presently paying rent to the City of Ann Arbor for the "privilege" of being able to provide, for free, medical services to the citizens of Ann Arbor (as are the other mainly-volunteer incorporations - Drug Help and Ozone House - also located in the building at 502 E. Washington Street - attempting to provide certain other types of much-needed services to people in the Ann Arbor-Washtenaw County Area); we recommend that City Council should be requested to not charge rent to those organizations now located in the facility at 500 and 502 E. Washington Street, Ann Arbor, for use of this city-owned building.

Recommendations as to what the City Board of Health's role should be in instituting these changes and programs:

(1) The City Board of Health should address itself immediately to the unmet health needs of Ann Arbor. In all possible instances it should set up, or advise other councils, boards, committees, or facilities, to establish and fund the programs detailed above.

(2) The City Board of Health should set up a Community Advisory Board to itself that will include representatives of those people whose needs are NOT being met by the present Health Care Delivery System in Ann Arbor.

(3) In instances where the City Board of Health does not have direct responsibility or direct decision-making power to change certain health conditions or laws; the City Board of Health should put pressure on those bodies or individuals who do have responsibility and/or decision-making power to make necessary cjamges in laws and conditions, and institute necessary programs.

(4) The City Board of Health should advise City Council to provide its building at 500 and 502 E. Washington Street, Ann Arbor, free of charge to the Free People's Clinic, Drug Help, Ozone House, and the Community Center Project.

(5) The City Board of Health should recommend that City Council set up public hearings on Health, to be held at the first possible opportunity (preferably within the next month).

Too often corrective measures and new programs are not implemented and instituted for the specified reason that "further study" is said to be necessary in planning for solutjions to the problems Ann Arbor is facing regarding unmet health needs. Our analysis of the crisis in health care delivery in Ann Arbor shows that further "study" of many of the problems, without taking immediate action to correct these problems, will be gross neglect on the part of public officials and medical professionals. To say that there are enought physicians in the Ann Arbor area to meet present health needs is to not be dealing realistically with the problems of accessibility, cost, and compassion in health care.

We hope that our sense of seriousness and crisis regarding many of these matters will move the Ann Arbor Board of Health to act immediately on these issues. The Free People's Clinic is more than willing to work with any and all individuals, committees, facilities, and boards to help rectify the inadequacies and inequities in the present health care delivery system in Ann Arbor and Washtenaw County.

Peace and Health,

/s/ Nancy

Nancy Lessin
Free People's Clinic
500 E. Washington St.
Ann Arbor, Michigan 48108

cc: Ann Arbor News
Huron Valley Advisor
Michigan Daily
Ann Arbor Sun
Ann Arbor City Council
Democratic Party, Ann Arbor, Washtenaw County
Republican Party, Ann Arbor, Washtenaw County
Human Rights Party, Ann Arbor, Washtenaw County
Washtenaw County Board of Health
League of Women Voters
Medical Committee for Human Rights, Ann Arbor

PEOPLE'S FREE MEDICAL CLINIC

NEWSLETTER

MEDICAL CARE IS A RIGHT, NOT A PRIVILEGE

October 15, 1970

Volume I
Number 9

The Clinic continues to grow. Open now three evenings per week (Monday, Wednesday, and Thursday) with three to five doctors on duty each evening, we are able to serve an ever increasing number of people. The work load on the day-time staff has become too great to provide a statistical breakdown of clinic visits this month, but the Clinic is seeing over 100 people per week. That means that since the Clinic opened May 4, we have treated over 1200 people.

WOMEN'S COUNSELING: The Women's Counseling Center still provides the best birth control and abortion counseling and referral service in the city. Their record on abortion referrals for women who come in early enough in virtually 100%. Women's Liberation has developed more confidence in the service they provide than in any other agency in the city.

The abortion Loan Fund provided $790 to needy women in interest free loans during September. The fund, however, is very nearly depleted at the present time. Contributions for the fund should be so earmarked and sent to: People's Clinic Support Fund, 3133 Guilford Avenue, Baltimore, Md. 21218.

STREET FESTIVAL: September 19 saw clear skies for the Free Clinic Street Festival. With a large measure of community cooperation thousands of people enjoyed an afternoon together. Music, balloons, food, tie-dying, bread and roses, Tarot reading, body painting, and beautiful people highlighted the day. Neighborhood people provided electricity for the bands, heat for the hot dogs, and the streets in front of their houses for the event. People helped willingly to staff the many booths. As a fund raising event the Clinic netted over $600, but the major success was in the fun that people had. Thank you all.

DAY STAFF AND CHILD CARE NEED HELP: The day staff at the Clinic is desperately in need of help. The work isn't particularly glamorous -- cleaning, mailing, answering the phone, helping pwopie who come in, keeping medical records, delivering laboratory

specimens, etc., but it is important. Since schools opened, much of the previously available help has dissipated The present staff cannot handle the load. If you have time available, even one afternoon a week, call 467-6040 and volunteer. The work is vital to the functioning of the Clinic.

The Child Care staff on clinic nights also need additional help, particularly on Wednesdays and Thursdays. The staff is doing a great job. Working with the children of patients, staff, and neighborhood kids, they are not simply providing a babysitting service, but trying to work creatively with the children to make their time at the Clinic a meaningful and helpful experience. If you can help any of the three evenings, even if only part-time, call the Clinic and volunteer, (467-6040).

FINANCES: The budget breakdown for the month of September is as follows:

Expenditures

Salaries	$270.00
Rent and Utilities	392.12
Medical Supplies	306.33
Non-medical Supplies	119.74
Administrative Expenses	97.12
Street Festival	265.04
Abortion Loans	790.00
TOTAL	$2240.35

Income

Monthly Pledges	$311.21
Presbytery of Baltimore	300.00
Street Festival	916.00
Fund Raising Movie	97.00
Misc. Contributions & Other Income	406.79
TOTAL	$2031.00

Net loss for the month of September: $209.35

Clinic expenses continue to grow as we provide more and more service to the people. Expenses now amount to well over $1000 per month. Pledges to the Clinic are now over $300. We still receive $300 per month from the Presbytery of Baltimore and $50 from the Medical Committee for Human Rights. People receiving services donate $100 to $150 per month. But to remain open we need additional help. If you haven't donated, or better yet, made a monthly pledge, do so today. The Clinic is able to remain open because of the people who believe in the principle of medical care as a right, not a privilege. Keep your contributions coming in.

We also need additional medical supplies, particularly anti-biotics, and can always use more doctors. We are very much in need of gynecologists who are most important to the Women's Counseling program. Physicians' samples of medicine are our biggest source of supply. Keep them coming.

In the next few weeks we will have a new brochure about the Clinic ready for distribution. It can be used to tell new people about what we do and what our purposes are. It will be an important fund raising leaflet. If you would like copies -- singly or in quantity -- let us know.

STAFF MEETINGS: Clinic Staff meetings are held a 8:00 p.m. at the Clinic on the last Sunday of every month. All staff and residents of the immediate community are invited to attend to participate in policy making and in working out the problems of providing good, "redtapeless" and humane medical care. People who have used the Clinic and who have any suggestions

or complaints are particularly requested to attend so that we may work together to solve our common problems.

FREE CLINIC ADOPTS NEW SYMBOL . . . .

The Free Clinic has taken on a new symbol to represent what it is about, replacing the symbols of Women's Liberation and the Baltimore Defense Committee. The new symbol, appearing on the front of this Newsletter, is our version of the traditional symbol of the medical profession. This symbol, the Caduceus, is an ancient one that was used in Mesopotamia prior to 2600 BC, the intertwining serpents being a symbol of the god who cured all illness. It contains signs for the four elements: the wand, earth; the wings (also the wings of Mercury), air; and the snakes, fire and water.

The symmetry of the Caduceus indicates the balance of opposing forces (good and evil, etc.) and shows that supreme state of strength and self control, and consequently health -- strength both on the physical and spiritual levels. The serpent is also an ancient symbol of wisdom.

It is with a certain sense of awe that the Clinic takes the ancient symbol and transmutes the sphere of unity (between the two wings at the top of the staff in the Caduceus) to the clenched fist of power. The fist represents the power of people working together -- implying the unity symbolized by the sphere. To end the oppression and exploitation in the medical institutions and in the world around us will require power and unity. For us this is particularly a process of change in health systems so that people are treated humanely when they are sick and will know that quality care is available to poor and rich alike.

We take the Caduceus and the fist together as symbolic of our slogan, "Medical care is a right, not a privilege." With wisdom and balance, the power of the people can make the medical institutions and all the institutions that affect our lives serve our needs.

Our mailing list has become huge! The work and expense involved in making mailings has become a real burden -- but one that is worth it for people genuinely interested in the Clinic. If you wish to remain on the mailing list and have not yet contributed or pledged, please send us $1.00 with the coupon below. If you haven't got the bread, and you want to remain on the mailing list, just let us know.

Clip and mail to: People's Free Medical Clinic, 3028 Greenmount Avenue
Baltimore, Maryland 21218

Name: _____

Address: _____ ZIP: _____

I wish to pledge $_____ per month to support the People's Free Clinic

Enclosed is my donation of $_____ to support the People's Free Clinic

_____ Sorry, I'm out of bread now, but please keep me up to date on Clinic activities.

BEST COPY AVAILABLE

PEOPLE'S FREE MEDICAL CLINIC

NEWSLETTER

MEDICAL CARE IS A RIGHT, NOT A PRIVILEGE

October 15, 1971 Vol. II No. 4

HEAD STREET FESTIVAL

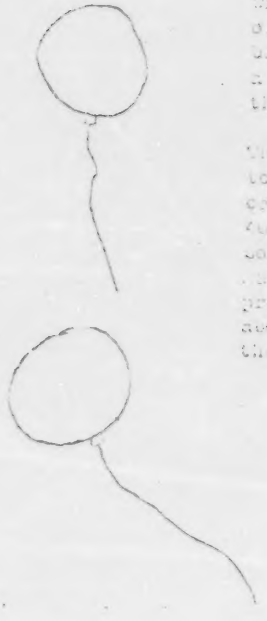
OCTOBER 23

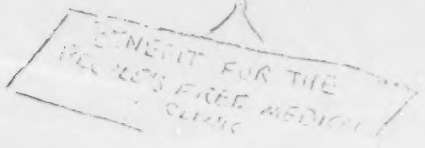
- for the benefit of the FREE CLINIC

10 A.M. TO 6 P.M.

At 100 and 200 blocks of East Head Street will come alive this Saturday with the sounds of some of Austin's best bands. There will be lots to eat and drink as well as games and a craft and flea market. Not to mention all the beautiful people!

The Clinic needs your help too! We'd like to have a hot meal ready, so give Terry a call some afternoon at the Clinic at 477-1040, and I'll bet know that you'll help sometime. We will also be staffing an information booth and could use your professional help there. Let Terry know about that too, or sign up on the sheet at the Clinic.





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GROWING COMMUNITY

CLINIC

Since the beginning the Free Clinic has seen itself as a community project, run by and for community people, and serving many of the medical needs of the immediate community. But, at the same time, the Clinic has provided services for a wider community that covers not only Waverly but the whole city and into the counties.

A few months ago we found it important and necessary to find new ways to give priority to community people. Young and old Waverly residents have begun to seek out our services more often and more regularly and we began making appointments for community people. Since then the word has been spreading and trust in the Clinic and its services has continued to grow.

With increased community use of the Clinic, we have encountered the problem of more patients than we can handle. We have had to face the fact that the Clinic can not come anywhere near meeting the medical needs of the larger Baltimore community, whose needs aren't being met in other institutions. As more people have been turned on to the Clinic we have faced the difficult task of turning people away. However, we realize that this is necessary if we are going to be really effective in making health care in our community more accessible and more meaningful. There's a lot to be done about changing some of the medical care (and lack of care) in this area. To move in this direction, we have to redirect some of our energies and concentrate on our immediate environment - our community. As our experiment in community care continues to work better and better, it is our hope that hundreds of other Baltimore communities will be able to open their own community Clinics. We envision that these new clinics, like ours, will belong to and be controlled by the people.

In September people made 470 visits to the Clinic - 197 of these were first visits by new patients and most of these new visits were by community people. About 45% of the visits made this month were by community people. Since the beginning 3078 people have made 7004 visits to the Clinic.

We look ahead to see this community project becoming more and more intricately involved with the people on the other side of our big window. We hope more community people will become a part of our staff and will come to use our services. In the near future we x wish to reach more people by word of mouth and door to door canvassing. We hope to become increasingly effective in primary and preventive medical care. And we need the continued support of all of you.

NEEDS: As always we continue to need supplies of drugs - like Flagyl, Tetracycline, vaginal cream and the like. And we'd like to take this little space to say thanks to the people who have given drugs in the past - especially some of the drug salesman who continue to be most helpful.

ONE FISCAL YEAR AT THE CLINIC

FINANCIAL STATEMENT - September 30, 1971
For fiscal year beginning July 1, 1971

RECEIPTS	PREVIOUS	SEPTEMBER	TOTAL
Pledges	750.00	339.75	1089.75
Contributions to the Abortion Loan Fund	27.00	0.000	27.00
Repayments to the Abortion Loan Fund	20.00	5.00	25.00
Contributions and Other Income	1444.19	640.00	2084.19
TOTAL	2250.69	990.75	3241.44

EXPENDITURES			
Rent and Utilities	987.04	527.39	1514.73
Salaries	713.04	445.05	1158.09
Medical Supplies	419.02	47.07	466.09
Administrative and Maintenance	472.78	158.27	631.05
Withholding Tax	14.79	0.000	14.79
TOTAL	2606.87	1223.98	3830.85
NET LOSS(-)	356.28(-)	233.23(-)	589.51(-)

Balance, July 1, 1971	7350.70
Net Loss since July 1, 1971	589.51
Balance, September 30, 1971	6761.19
Balance, Abortion Loan Fund	7.72
Balance, Working Fund, September 30, 1971	6753.90

HELP

- - - -

4

WONAAC

TO ..W ..ITC.. CO..S ..:

Throughout history few things have been ..ore universal or known fe.er national boundaries than the suffering of ..o..en fro.. the denial of our right to control our own lives and our own ..... bodies. Today, ..o..en are uniting to.ether to for.. a national coalition to fight for the repeal of all abortion laws and for the corollary demands of no forced sterilizations and repeal of contraceptive laws. This coalition forme.. at Columbia University on July 10, 1971 and is called ..O..AAC (..o..en's ..ational Abortion Action Coalition). This national coalition represents a broad base of ..o..en fro.. all geographic areas, races, religions, and classes. ..aryland is in the process of organizing a state wide group to support the goals of ..O..AAC. This group, ..o..en's ..ight to Choose of ..aryland is organizing to support legislation, legal action and a nationally coordinated mass demonstration in ..ashington ..C. and San Francisco on ..ovember 20. This ..arch will help express the depth of sentiment of all ..o..en for the repeal of all anti-abortion laws which now hurt ..o..en. ..o..en's ..ight to Choose of ..aryland needs your support both in ti..e and money to continue the campaign against abortion laws. If you cannot contribute y your ti..e please send us money, or ..ore.. our campaign!

Illegal abortions cost a lot. .o..etimes they cost a woman her life.

CLIP and ..AIL to: ..o..en's ..ight to Choose of ..aryland
3020 Greenmount Ave.
Baltimore, ..aryla.., 21218
301/366-8479

_____ I (we) endorse the ..o..en's ..ight to Choose of ..aryland.
_____ I have enclose.. my contribution to help this campaign.
_____ I would like to give my time to help the campaign.

..A..:_____ PHO..:_____
A..RE..:_____
CI..:_____ STATE:_____ ZIP CO..:_____

O..GA..IZATIO../..E..BER/OCCUPATIO..:_____

HEALTH CARE IN CHINA

- a free clinic forum
- SUNDAY, OCTOBER 24 - 8 PM
- AT THE CLINIC

-the first of what we hope will be a continuing thing.

Two members of the Committee of Concerned Asian Scholars recently returned from a month's stay in the People's Republic of China will speak at the Clinic forum. While in China a group of 15 travelled officially as the Friendship Delegation of the Committee of Concerned Asian Scholars visiting Canton, Shanghai, Loochow, Nanking, Peking, Tachair, Taiyuan, Sian, and Yenan, and travelled in six provinces. They will speak on the Chinese health care system as a part of Modern China and will show some slides.

(Also, "China-1971" another meeting, the same evening-
Stony Man Friends meeting
5110 N. Charles St. 8:00 P.M.
Two others from the same group will be there. Take your pick.

CLINIC WORK DAY

Saturday, October 16

10 AM - wear old clothes, bring some tool, and join in cleaning, painting, & fixing!!!

1971

NATIONAL FREE CLINIC COUNCIL

STATEMENT OF PURPOSE

All institutions of our society are being confronted by a growing crisis of performance, with bureaucratic process replacing necessary responses to individual and community needs and with organizational control supplanting quality of service. This crisis is highly visible within the health care community in the United States.

The Executive Committee of the National Free Clinic Council believes that quality health care is a right of every individual, not a privilege dependent on socioeconomic status, social ethic, or geographical location. We further believe that quality alternatives to existing methods of health care must be developed and implemented in order to make available both facilities and personnel for those individuals who are defined or who define themselves as medically indigent.

We believe that health care transcends clinical medicine. Health for an individual depends on fulfillment of basic human needs, both physical and mental. Health services, therefore, should be provided for all people within a context of total health -- individual, community, and social health. Total health care implies adequate personnel and facilities, full access to services, and a major new emphasis on preventive medicine via public education, all of which should involve the community being served in both planning and implementation of its local health care system.

Within the past four years a unique concept of community-based health care has evolved into an explicit attempt to resolve some important aspects of the crisis of performance in health care ...The free clinic "movement" has become part of the massive change now occurring within the health care community.

Formed in 1968, the National Free Clinic Council has evolved with the free clinic "movement" and is now prepared to begin full-scale national operation. The National Free Clinic Council has the following operational objectives:

1. To provide a focal point for the sociomedical momentum of the free clinic "movement."
2. To develop and maintain a system of information dissemination concerning all aspects of free clinic operation.
3. To gain access to health care funding which is available at the national level and distribute such monies equally to member free clinics.

4. To sponsor and administer an annual National Free Clinic Council Meeting.
5. To provide consultation services both for improvement of quality of services being rendered in established free clinics and for establishment and organization of new free clinics.

The National Free Clinic Council will not assume any administrative control of individual free clinics; the autonomy of each facility must be preserved in order to define, confront, and effectively deal with each community's needs.

The future goal of the National Free Clinic Council is to overcome the crisis orientation of most of the currently operational free clinics. The critical unfulfilled needs in drug abuse, venereal disease, birth control and abortion, malnutrition, and dental health are now requiring full attention of most free clinics. The attainment of national legitimization for free clinics will aid in eliminating some of the desperate quality pervading the operation of such facilities at the present time and permit the necessary expansion into all primary health care services.

---- PRIMUM NON NOCERE ----